



Instructions for Completing Intake Paperwork for the Low Fee Clinic

Welcome to Samaritan Center of Puget Sound. Please take a few minutes to complete the following paperwork in this packet before you meet with your therapist.

Client Referral Information*

Complete one of these forms. This helps us know how you heard about Samaritan Center and if you would like us to send a thank you card to whomever referred you.

Client Information*

Complete one of these forms for yourself. Additional persons are to complete their own forms.

Informed Consent for Use of Email*

Please read through this form then sign and date. If you do not use email, please let your therapist know. You do not need to fill out the form if you do not use email.

Notice of Privacy Practices (one copy for you)*

You may read this now or later after your first session. Please keep it for your records.

Download the following form separately from the therapist's profile page on Samaritanps.org, as it contains information unique to your therapist:

Disclosure Statement (two copies – one for you and one for Samaritan)*

Please read this form carefully; on the last page, sign and date once above and below where indicated (acknowledging receipt of the Disclosure Statement and the Notice of Privacy Practices). Each additional person must also read and double-sign the last page. Repeat this for the second copy. Your therapist will sign and return your copy.

When you finish completing this packet, please keep it in your possession and hand it to your therapist when s/he meets you.

Thank You.

Samaritan Center

CLIENT REFERRAL INFORMATION

For Confidential Use Only

Thank you for choosing Samaritan Center of Puget Sound.

Name (s) _____ Today's Date _____

Are you a returning client? ☐ Yes ☐ No

Type of Counseling you are seeking:

Individual _____ Relationship (or Couple) _____ Child _____ Family _____

Age of Primary Client ☐ Under 13 years

(please check one) ☐ 13-18 years

☐ 19-64 years

☐ 65 + years

Did you come because you had a specific therapist in mind? ☐ Yes ☐ No Name of therapist _____

If so, is the therapist on your insurance provider list? ☐ Yes ☐ No ☐ Don't Know

How were you referred to the counselor/agency? (please include name – optional)

☐ Friend _____

☐ Relative _____

☐ Medical Professional _____

☐ Clergy _____

☐ Web Search _____

☐ Insurance Company _____

☐ Other _____

May we contact them to thank them? ☐ Yes ☐ No

Contact Address/Information: _____

We appreciate your help to make our services more widely accessible.

CLIENT INFORMATION
For Confidential Use Only

Chart # _____

Legal Name _____ Today's Date _____

Address _____
Street Address Apartment #

City State Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____
Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No

E-Mail Address _____ Birthdate _____ Age _____

Emergency Contact _____
Name and phone number

Occupation _____ Employer/School _____

Number of years (or highest level of) education _____

Gender _____ Relationship (or Couple) Status _____ Race/Ethnicity _____

Name/Address of financially responsible party if other than client *(For minors or anyone using 3rd party, non-insurance payor.)*

If client is a minor, name/address/phone of custodial parent, if different from name above _____

Gross annual family income \$ _____ per year Number dependent on this income _____

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)*)
Clarify if client is a minor from two households *(Include any different last names.)*

Name	Age	Gender	Relationship	Living with you?
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Religion _____ Place of worship _____

Is it important for you to have spirituality included in your therapy? ☐ Yes ☐ No

PLEASE CONTINUE ON PAGE 2 ➡

CLIENT INFORMATION
For Confidential Use Only

Chart # _____

Physician's Name _____ Phone _____ Date of last exam _____

Physician's Address _____

It is our practice to coordinate care with the client's physician when this would be helpful. If you agree that we may contact your physician, please check here: ☐ (Please sign a release of information with your therapist for this purpose.)

List any surgeries or illnesses you have had the past five years _____

List any medications, including the amount that you currently take or have taken in the past 3 months:

Medication	Dosage	Purpose	Start Date

What is your purpose in coming to Samaritan at this time? _____

Have you done previous counseling/therapy? ☐ Yes ☐ No If yes, when? _____

Name of Previous Therapist(s) _____ Purpose/issues at that time _____

Do you want to be added to our mailing list for e-newsletters and/or print newsletters? ☐ Yes ☐ No

FOR THERAPIST'S USE

Therapist: _____ **Office:** _____ **Fee (90791):** _____ **Fee (90834/47):** _____ **Date:** _____

Payment: ☐ Ins* ☐ Samaritan Fund (requires therapist's application) ☐ EAP ☐ 3rd Party Non-insurance Guarantor (i.e., church) ☐ Self-pay

* Insurance Information form must be completed, double-signed by client, stapled to photocopy of medical card, included with intake paperwork.
☐ Check if insurance paperwork and/or photocopy of medical card is not included and will be submitted later.

File: ☐ Individual ☐ Couple ☐ Family (Number of family members _____) ☐ Group ☐ Child/Adolescent

If Couple or Family, check one: ☐ **Primary client** ('patient' for insurance purposes; contact for scheduling) ☐ **Additional client(s)**

CLIENT INFORMATION
For Confidential Use Only

Chart # _____

Legal Name _____ Today's Date _____

Address _____

Street Address

Apartment #

City

State

Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____

Leave Message? ☐ Yes ☐ No

Leave Message? ☐ Yes ☐ No

Leave Message? ☐ Yes ☐ No

E-Mail Address _____ Birthdate _____ Age _____

Emergency Contact _____

Name and phone number

Occupation _____ Employer/School _____

Number of years (or highest level of) education _____

Gender _____ Relationship (or Couple) Status _____ Race/Ethnicity _____

Name/Address of financially responsible party if other than client *(For minors or anyone using 3rd party, non-insurance payor.)*

If client is a minor, name/address/phone of custodial parent, if different from name above _____

Gross annual family income \$ _____ per year Number dependent on this income _____

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)*)

Clarify if client is a minor from two households *(Include any different last names.)*

Name	Age	Gender	Relationship	Living with you?	
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Religion _____ Place of worship _____

Is it important for you to have spirituality included in your therapy? ☐ Yes ☐ No

PLEASE CONTINUE ON PAGE 2 ➡

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Chart # _____

Physician's Name _____ Phone _____ Date of last exam _____

Physician's Address _____

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List any medications, including the amount that you currently take or have taken in the past 3 months:

Medication	Dosage	Purpose	Start Date

What is your purpose in coming to Samaritan at this time? _____

Have you done previous counseling/therapy? ☐ Yes ☐ No If yes, when? _____

Name of Previous Therapist(s) _____ Purpose/issues at that time _____

Do you want to be added to our mailing list for e-newsletters and/or print newsletters? ☐ Yes ☐ No

FOR THERAPIST'S USE

Therapist: _____ Office: _____ Fee (90791): _____ Fee (90834/47): _____ Date: _____

Payment: ☐ Ins* ☐ Samaritan Fund (requires therapist's application) ☐ EAP ☐ 3rd Party Non-insurance Guarantor (i.e., church) ☐ Self-pay

* Insurance Information form must be completed, double-signed by client, stapled to photocopy of medical card, included with intake paperwork.
☐ Check if insurance paperwork and/or photocopy of medical card is not included and will be submitted later.

File: ☐ Individual ☐ Couple ☐ Family (Number of family members _____) ☐ Group ☐ Child/Adolescent

If Couple or Family, check one: ☐ **Primary client** ('patient' for insurance purposes; contact for scheduling) ☐ **Additional client(s)**

Informed Consent for the Use of Email

Samaritan clients who wish to communicate with their therapist and/or administrative staff using email are welcome to do so. However, there are a number of privacy concerns and potential risk factors that should be considered before transmitting confidential information by email.

General concerns include: email is immediately broadcast worldwide and can be received by unintended recipients; email messages can be forwarded without the sender's or intended recipient's permission or knowledge; email can easily be misaddressed; back-up copies of emails may exist after the sender or the recipient has deleted them; and email is easier to falsify than documents that are signed and sent by regular mail.

Privacy concerns related to a one's personal health information also need to be considered. It is the policy of Samaritan to make all email messages concerning diagnosis and/or treatment part of that client's medical record and to treat these with the same degree of confidentiality as other portions of the medical record. (Please see your therapist's disclosure statement for details.) Samaritan takes all reasonable means to protect clients' confidentiality but cannot guarantee the security and confidentiality of email communication. Please read the following information outlining Samaritan's conditions for the use of email.

- Samaritan Center of Puget Sound cannot guarantee that electronic communications will be private. Samaritan takes reasonable steps to protect confidentiality but is not liable for improper disclosure of confidential information not caused by negligence or misconduct.
- If the client chooses to use email, the client is responsible for informing Samaritan of any limitations to the kind of information that will be sent by email.
- The client is responsible for protection of their own password or other means of access to email sent or received. Samaritan is not liable for breaches of confidentiality caused by the client.
- Because employees do not have a right of privacy in their employer's email system, clients should not use their work/business system to send or receive confidential medical information.
- When an email is received by a Samaritan therapist or administrative staff person, there will be an attempt made to read it promptly and, when appropriate, respond. However, Samaritan cannot assure a specific time frame and suggests sending a follow-up email or phone call if some time has passed.
- Emails concerning diagnosis and/or treatment become part of the client's medical record and is available to certain authorized entities such as health care providers and insurers for the purposes of treatment and reimbursement. While emails may be forwarded within the agency for these purposes,

Samaritan will not forward the email outside the agency without the consent of the client or as required by law (per your therapist's disclosure statement).

- **Email should not be used when transmitting sensitive medical information.**
- **Email should not be used in the case of a medical emergency.**

I have read the above privacy concerns and conditions for the use of email and consent to the use of email for communications to and from Samaritan Center of Puget Sound.

Signature of Client

Date of Signature

Printed Name of Client

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We have a legal responsibility under the laws of the United States and the state of Washington to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on March 26, 2013 and will be in effect until we replace it.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at Samaritan Center of Puget Sound. These changes could also affect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice. When you are finished reading this notice, you may request a copy of it at no charge to you.

If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no additional charge to you.

Here are some examples of how we use and disclose information about your health information.

Section I: Permissible uses and disclosures without your written authorization.

We may use or disclose your health information without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object.

If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.

7. When required or permitted to do so by law. For example, to appropriate authorities if your therapist reasonably believes that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access your health information; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law
8. We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

Section II

With written permission: We may use or disclose your health information to anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.

Psychotherapy Notes: Notes recorded by your therapist documenting the contents of a counseling session with you ("Psychotherapy Notes") are not part of your health information. They will be used only by your therapist and will not otherwise be used or disclosed without your written authorization.

As a client of Samaritan Center of Puget Sound, **you have these important rights:**

- A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.
- B. You can ask us for photocopies of the information in part "A" above.
- C. You will be charged a fee for making these photocopies, based on the total number of pages. For more information about the current price per page, contact the Samaritan front office.
- D. You have a right to a copy of this notice at no charge.
- E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.
- F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.

- G. You can make a written request that we amend the information in part “A” above.
- H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.
- I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.
- J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center’s operations. This can go back as far as six years, but not before April 14, 2003.
- K. If you request the accounting in “J” above more than once in a 12 month period we may charge you a fee based on our actual costs of tabulating these disclosures.
- L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person:

HIPAA Security Officer:	Address
Matthew Percy, Psy.D. Telephone: (206) 527-2266 Fax: (206) 527-1009 E-mail: mpercy@samaritanps.org	Samaritan Center of Puget Sound 564 NE Ravenna Blvd. Seattle, WA 98115

- M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

Terms Important in Understanding the HIPAA Privacy Rule

Health Information:

Any information, whether oral or recorded in any form, created or used by health care professionals or health care entities.

Individually Identifiable Health Information: A subset of Health Information that either identifies the individual or that can be used to identify the individual.

Protected Health Information (PHI)

Individually Identifiable Health Information becomes Protected Health Information when it is transmitted or maintained in any form or medium. More specifically, PHI is information that relates to the past, present or future physical or mental health condition of an individual; or the past, present or future payment for the provision of health care to individual; and that identifies the individual or could reasonably be used to identify the individual.

Psychotherapy Notes

Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or group, joint or family counseling session, and that are separated from the rest of the individual's medical record.

Use and Disclosure

The privacy rule defines "use" as the sharing, employment, application, utilization, examination or analysis of individually identifiable health information within an entity that maintains such information.

The privacy rule defines a "disclosure" as the release, transfer, provision or access to, or divulging in any other manner of information outside the entity holding the information.

The definition of the privacy rule specifically excludes information pertaining to medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following: diagnosis, functional status, the treatment plan, symptoms, prognosis and process to date.