



Adirondack Samaritan Counseling Center

A nonprofit mental health agency serving Warren, Washington, and Saratoga Counties since 1983

15 Boulevard, Hudson Falls, NY 12839 • (518) 747-2994 • Fax: (518) 747-2996

Financial & Insurance Agreement

I understand that in order to provide quality professional counseling; Adirondack Samaritan Counseling Center must charge a fee for its service.

I also understand that ultimately I am the responsible party for all services provided by Adirondack Samaritan Counseling Center who will bill my health insurance company for services provided to my children or myself.

It is your responsibility to contact your insurance company to obtain the following information:

- **The amount of your co-pay.**
- **You need to know whether or not you need to obtain a referral or preauthorization.**
- **If your scheduled clinician is a participating provider.**

Any changes made to your insurance policy need to be reported to our business office immediately in order to keep current and accurate records. Failure to do so will result in being charged at the full fee.

I agree to pay the portion of the charge, which the insurance company states is my responsibility, which may include a deductible amount, a percentage of the charge for each session, or because coverage was not in effect.

I also agree that the Samaritan Center will wait for the insurance portion of the charge until the insurance company pays the amount, then I am responsible to pay the Samaritan Center any amount that I receive for services rendered, up to the full, actual charge per session. I will endorse the insurance check to the Samaritan Center or write a check equal to that amount, within one week of receiving it.

I herewith give my permission to the Adirondack Samaritan Counseling Center to perform any mental health assessment and treatments as necessary. Furthermore, consent to release to my health insurance company (if applicable) information necessary to process any request for insurance benefits. I also give permission for Adirondack Samaritan Counseling Center to inform my primary physician and/or referring professional of my participation in counseling and any medications recommended by the Center's clinical staff. I also authorize my insurance company to pay benefits directly to the Adirondack Samaritan Counseling Center.

I have read this agreement and accept all of its terms and conditions. I also understand that this agreement may be renegotiated if circumstances change.

Signature _____ Date _____

Name(printed) _____

Witnessed _____ Date _____



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Patient Information

Name: _____

Address: _____

City, State, and Zip: _____

Home: _____ Cell: _____

Place of Employment: _____

Work: _____ Ext: _____

Date of Birth: _____

Gender: Male Female

Marital Status

Single Married Separated Divorce

Spouse Name: _____

People In Household:

Names: _____ DOB: _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Insurance Information

Insurance Company: _____

Policy Holder: _____

ID#: _____ GRP#: _____

DOB: _____

Employer: _____

Referral Source

Clergy EAP Health Insurance
 Family/Friend Legal System Former Client
 Media Physician School
 Self Social Agency Other

Religious Affiliation

Catholic Baptist Jewish Other
 Reformed Unitarian Lutheran None
 Pentecostal Episcopalian Presbyterian
 Methodist Community Church

Church: _____

Pastor/Rev/Priest: _____

Employment Status

Full Time Part Time Unemployed
 Retired Volunteer Home Maker
 Full Time Student Part Time Student

School Attending: _____

Highest Level of Education Completed: _____

Pre-Therapy Evaluation

What is your primary concern that you would like to address in counseling?

How has this affected your...

	not at all			very much	
Marriage/Partner	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Family	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Job Performance	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
School Performance	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Friendships	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Finances	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Health	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Anxiety Level	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Mood (s)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Sexuality	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Eating Habits	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Sleep	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Concentration	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Parenting	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Anger	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Do you have concerns about abuse? yes no

physical emotional sexual

Do you ever think of committing suicide? yes no

Have you ever attempted suicide? yes no

Do you presently have suicidal thoughts? yes no

Have you had previous counseling? yes no

Medical Information

Primary Care Physician: _____

Address: _____

Phone: _____

Date of last physical exam: _____

Allergies: _____

Have you ever been hospitalized? yes no

When? _____

For what reason? _____

Have you ever had a major illness? yes no

Which ones? _____

Are you presently on medications? yes no

List: _____

Dosage: _____

Is there substance abuse in your family? yes no

Relationship: _____

Do you have concerns about substance abuse? yes no

Do you drink alcoholic beverages? yes no

How many per week? _____

Do you smoke? yes no

How many per day? _____



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****PLEASE NOTE ****

**WE REQUIRE 24 HOUR NOTICE
TO CANCEL APPOINTMENTS.
MISSED APPOINTMENTS ARE NOT
A COVERED BENEFIT OF
YOUR INSURANCE COMPANY
YOU WILL BE CHARGED
OUR FULL FEE.**

INITIAL HERE



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Release for Primary Care Physician

Name: _____ DOB: _____

I do hereby consent to **Adirondack Samaritan Counseling Center** to obtain information and/or records from and release information and/or records to:

(Primary Care Physician)

(Address)

(Phone) (Fax)

I authorize the following information to be exchanged:

- Presence in treatment (including admission/discharge dates)
- Psycho social assessment including diagnosis and mental status
- Description of treatment, progress and prognosis
- Medical history

This information is needed for the following purpose(s):

- To facilitate assessment, evaluation and/or treatment
- To coordinate treatment with other providers

I understand that this authorization will expire one year from the date signed or on this date: _____.

I understand that the above information is protected by Mental Hygiene Law 33.13 governing confidentiality of clinical records and/or by Federal Regulation 42 CFR, Part 2 governing confidentiality of Alcohol and Drug Abuse Records and cannot be disclosed without my written consent unless otherwise provided for in the law or regulations. I understand that I need not consent to the release of information in order to obtain services.

I choose to do so willingly and voluntarily for the purpose(s) stated above. I understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on my consent. Re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization. I understand that this information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

(Client signature) (Date)

(Parent or Guardian signature) (Date)

(Witness signature) (Date)



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United Way Demographic Survey

Please answer the following questions by checking the appropriate box. If you are unsure of an answer to a question, please give the best answer you can. Check only one box.

1. Which category best describes your age?
 Under 18 18-24 25-34 35-44
 45-54 55-64 65-74 75 and over
2. Are you male or female? Male Female
3. What is your racial background?
 American Indian or Alaskan Native Asian or Pacific Islander
 Black/African-American White/Caucasian
4. Are you of Spanish or Hispanic origin or ancestry? yes no
5. Which of the following categories best describes your marital status?
 Married Separated Never married Widowed Divorced
6. What is the highest grade you completed in school?
 8th grade or less some high school high school graduate
 some college college graduate post grad-work
7. How many adults other than yourself live in your household?
 0 1 2 3 4 5 6 7 8 9 10 11 or more
8. Number of children in your household?
 0 1 2 3 4 5 6 7 8 9 10 11 or more
9. Which of the following best describes your household's income before taxes last year?
 less than \$20,000 \$20,000-39,999 \$40,000-59,999
 \$60,000-79,999 \$80,000 or more



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Notice of Adirondack Samaritan Counseling Center Privacy Practice

This notice tells you how we make use of your Protected Health Information (PHI) at our Center, how we might disclose your health information to others and how you can get access to the same information.

Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a legal responsibility under the laws of the United States and the state of New York 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.

The effective date of this notice is September 2013.

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 PHI. This includes health information we will receive about you or that we create here at Adirondack Samaritan Counseling Center. These changes could also affect how we protect the privacy of any of your PHI we had before the changes.

When we make these changes, we will also change this notice and upon your request will send a copy or provide a copy at your next appointment. We will also post an updated version on our website.

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.

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

Here are some examples of how we use and disclose information about your PHI:

We may use or disclose your health information; with your authorization

1. To your physical 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 provided for you.
5. To our own staff in connection with our Center's operation. Examples 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 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.

By law, we may disclose private health information in a number of circumstances in which you do not have to consent, give authorization, or otherwise have an opportunity to agree or object. We may use or disclose your health information; without your authorization

1. 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 emergency, to go ahead and use or disclose your health information that are necessary to respond to the emergency.



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2. To proper authorities in the event of suspected or reported abuse or maltreatment (as defined by the Social Services Law) of any child under the age of 18 or any elder.
3. To proper authorities in the event you or someone else is in clear or imminent danger.

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.

As a client of Adirondack Samaritan Counseling Center, you have these important rights:

1. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.
2. You can ask us for photocopies of the information in part “1” above.
3. We will charge you a reasonable cost-base fee.
4. You have a right to a copy of this notice at no charge.
5. 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 spoke at this Center, and we are treating a child or whom you have lawful custody.) Your written per request must specify the alternative means and location.
6. You can make a written request that we place other restrictions on the way 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.
7. You can make a request that we do not disclose your PHI to your Health Insurance provider if you elect to pay for sessions through Adirondack Samaritan out of pocket.
8. You can make a written request that we amend the information in part “1” above.
9. 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.
10. You may make a written request that we provide you with a list of those occasions where we or 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 (6) years.
11. If you request the accounting in “10” above more than once in a 12 month period we may charge you a fee based on our actual cost of tabulating these disclosures.
12. 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:

Compliance Officer: Karen Weidner
 Telephone: (518)747-2994
 Fax: (518)747-2996
 Email: kweidner@adksamaritan.org
 Address: 15 Boulevard, Hudson Falls, NY 12839

13. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with the address upon written request.
14. Breach Notification: If there is a breach of unsecured personal health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Receipt of Adirondack Samaritan Counseling Center

I (print name) _____, have read the copy of the Adirondack Samaritan Counseling Center’s Notice of Privacy Practices.

Signature

Date