SAMARITAN COUNSELING CENTER HAWAIʻI

Client Information Sheet

First Date Seen: _____ (Referral Date: _____) Counselor:_____

Location: TELE___ OFFICE_____ HOME___ Client ID: _____

Primary Client: _____ **Preferred Name:**_____

*If client is a **minor,** name of parent/guardian:*_____ *Relationship:*_____

Address: _____**City/Zip**_____ **Cell Phone:**_____

Date of birth: _____**SS#**_____ **Work Phone:**_____

Email address: _____ **Home Phone:**_____

Additional Client: _____ Relationship:_____

Address *(if different*):_____ Cell Phone:_____

Date of birth: _____**SS#**_____ Work Phone:_____

***Email address**:* _____ Home Phone:_____

Preferred Pronouns: _____

Sex: (please circle one) Male Female Transgender Self-Describe _____

Residence: Own ___ Rent ___ At risk of houselessness ___ Shelter ___ Houseless ___

Marital Status: (please circle one) Single Married/Civil Union Divorced Widowed Separated Other

Employment: (please circle one) Employed Unemployed Student Retired Disability Other

Race/Ethnic Background: (please circle as applicable)
African American American Indian Asian Caucasian Hawaiian Hispanic Filipino Pacific Islander Other

Spirituality: Faith/spiritual/religious affiliation (if applicable): _____
My faith/spirituality is a source of strength for me. Disagree Neutral Agree Strongly Agree

Family/Household Members: Number of people who live with you: _____

Name	Age	Employed (Yes/No)	Student (Yes/No)	Relationship

Emergency Contact

Name:_____ Phone:_____ Relationship: _____

Referral Information
How did you learn about Samaritan Counseling Center Hawaiʻi? _____

SAMARITAN COUNSELING CENTER HAWAIʻI

Client Information Sheet, cont.

Medical Information

Name of physician_____ Phone #_____

Name of medication Dosage For what condition

_____

_____

Previous Counseling Information

Have you had previous counseling or psychotherapy, substance abuse treatment, or hospitalization for emotional or psychiatric treatment? Yes _____ No _____

If yes, with whom, dates of therapy or hospitalization and the reason:

Therapist/Institution Date Reason

_____

_____

Present Concerns

What would you like to see happen as a result of psychotherapy or counseling?

_____

_____

Please check any of the following that you are currently experiencing:

Anger____	Anxiety_____	Depression_____	Suicidal thoughts_____	Identity concerns_____
Guilt_____	Fear_____	Sadness_____	Marital problems_____	Sexual concerns_____
Panic_____	Fatigue_____	Nightmares_____	Eating problems_____	Sleep problems_____
Loss of faith in:	God_____	Self_____	Others_____	
Loss of:	Hope_____	Love_____	Meaning_____	Self respect_____
Religious doubts_____		Death of loved one_____		

OPTIONAL: I can feel challenged when…

_____

OPTIONAL: Some things that help me with my challenges are…

_____

SAMARITAN COUNSELING CENTER HAWAI'I

Clinical Policies

Samaritan Counseling Center Hawai'i (SCCH) welcomes you as a client. It is important for you to be informed about the nature of counseling or psychotherapy, the fees charged for our services, and your rights as a client.

Fees and Payment

SCCH offers services at a rate of $175 per 50-minute session. SCCH counselors are providers for several health insurance companies and accept the allowable fees set by these insurance companies. A sliding scale fee schedule is available based on income level and financial need. There is also a Client Assistance Fund (CAF) for those without the ability to pay for services, dependent on financial need and funds availability. _____**(Int)**

Full payment or co-payment should be made by cash or check at each session. Checks are payable to Samaritan Counseling Center Hawai'i. Requests for delayed payment should be discussed with your counselor. ____**(Int)**

Appointments

Each counselor schedules his/her own appointments. The usual length of each session is 50 minutes. When you make an appointment, your counselor agrees to make his/her services available to you during this time and you agree to keep your appointment and pay the agreed upon fee. If you are unable to keep your appointment, call your counselor at least 24 hours before your appointment. **I understand that I am responsible for paying for any appointments not canceled 24 hours in advance. _____(Int)**

Counseling and the General Course of Treatment

SCCH counselors work within the standards and ethical guidelines of Hawaii state licensing laws, professional associations, and the Solihten Institute. SCCH counselors also respond to the spiritual and theological needs of clients who choose to incorporate their values, beliefs, and religious affiliations/spirituality into their therapy.

No audio or video recording will be done without the prior knowledge and consent of all parties. ____**(Int)**

Counseling sessions follow a general course of treatment, which includes: intake, assessment, goal setting and treatment planning, course of treatment, and discharge.

- **Intake** covers the initial call and contact with the counselor. During this time, certain essential demographic information is collected and the first appointment is set up.
- **Assessment** may take from one to four counseling sessions. Through this period the counselor is establishing a relationship and obtaining information to develop a proper course of treatment.
- **Goal setting and treatment planning** are the outcome of the assessment process. This is a phase when you work out what goals and what amount of time is needed to accomplish the goals which are being set.
- While treatment is occurring from the initial session, the **course of treatment** is that period of time established to work in therapy on the goals and objectives, which have been established in the treatment plan.
- **Discharge** is the end phase of treatment in which the focus is ending the treatment and establishing how you may maintain the skills learned from the therapy.

Mutuality and Receipt of Notice of Privacy Practices

The best therapy occurs when there is open communication between the counselor and client. Please feel free to raise any questions or concerns you have with your counselor at any time. Your counselor will discuss these policies with you at the beginning of therapy. **I have received a notice of privacy practices. _____(Int)**

Consent for Treatment

I am voluntarily entering counseling at Samaritan Counseling Center Hawai'i. I have read and understand this statement and agree to abide by these policies, and I have received a copy of the Notice of Privacy Practices.

Client name_____Parent's signature_____
(If client is a minor)

Client signature _____ Date _____

Witness signature_____ Date_____

SAMARITAN COUNSELING CENTER HAWAI'I

Consent to VideoTherapy

"**VideoTherapy Services**" involves the delivery of health care services using electronic communications, information technology or other means between a health care provider employed by or otherwise contracted with the Center ("**Provider**") and a patient who are not in the same physical location. VideoTherapy may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- Electronic transmission of clinical records, images, personal health information or other data between a member and a Provider;
- Interactions between a patient and Provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files.

The vendor of the electronic systems used for VideoTherapy services has represented that it incorporates industry standard network and software security protocols to protect the privacy and security of health information.

Possible Benefits of VideoTherapy

- Can be easier and more efficient for you to access clinical care and treatment from a Provider.
- You can obtain clinical care and treatment at times that are convenient for you.
- You can interact with a Provider without the necessity of an in-office appointment.

Possible Risks of VideoTherapy

- Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
- The inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.
- Your Provider may not able to provide clinical treatment for your particular condition via VideoTherapy and you may be required to seek alternative care.
- Delays in clinical evaluation/treatment could occur due to failures of the video technology.
- Security protocols or safeguards could fail causing a breach of privacy.
- Given regulatory requirements in certain jurisdictions, your Provider's treatment options may be limited.

By accepting this Consent to VideoTherapy, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via VideoTherapy is an evolving field and that the use of VideoTherapy in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of VideoTherapy may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using VideoTherapy, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these VideoTherapy services.
7. I understand that no audio or video recording will be done without the prior knowledge and consent of all parties.
8. I agree and authorize my Provider and Center to share information regarding the VideoTherapy exam with other individuals for treatment, payment and health care operations purposes as allowed by law.
9. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment. Otherwise, this consent will be considered renewed upon each new VideoTherapy consultation with my Provider.

CONSENT FOR VIDEOTHERAPY

I have read this special Consent to VideoTherapy carefully, and understand the risks and benefits of the use of VideoTherapy in the course of my treatment. I have discussed it with my Provider, and all of my questions have been answered to my satisfaction. **I hereby give my informed consent for the use of VideoTherapy in my medical care and authorize Provider to use VideoTherapy in the course of my diagnosis and treatment.**

I have been offered a copy of this consent form _____ **(Int)**

Client name_____Parent/Guardian's signature_____

Client signature _____ **Date** _____

Client email (please print) _____

Witness signature_____ **Date**_____

SAMARITAN COUNSELING CENTER HAWAI'I

Insurance Information Sheet

Primary Insurance:

Primary Insurance Company:_____Eff. Date of Coverage:_____

Member ID#_____ Group#_____ **Copay $_____ per visit**

Policy Holder Name (if different from client):_____ Relationship_____

For Tricare: DoD Benefits # (11 digits) _____ **OR** Sponsor's Social Security # _____

Sponsor's Name _____ Relationship _____ Birthdate_____

Address _____ Home/Cell #_____

_____ Work #_____

Employee Assistance Program: EAP: _____ Auth. # _____ # Sessions: ____

Once you have completed your EAP sessions, you may be able to continue counseling using your primary insurance.

Do you have secondary insurance? Yes_____ No_____

If yes: Secondary Insurance Company: _____ Eff. Date of coverage:_____

Member ID#_____ Group #_____

Policy Holder Name (if different from client):_____ Relationship_____

General Insurance Information

Relationship to the Insured:	Self_____	Spouse_____	Child_____	Other_____
Marital Status:	Single_____	Married_____	Other_____	
Employment Status:	Employed_____	Full time student_____		Part time student_____
Client's condition related to:	Employment? Yes_____		No_____	
	Auto Accident? Yes_____		No_____	
	Other Accident? Yes_____		No_____	

Do you authorize payment to go directly to Samaritan Counseling Center Hawai'i? Yes_____ No_____

If you do not have health insurance or need financial aid, we offer a sliding fee scale. You may also qualify for the Client Assistance Fund.

Circumstances contributing to needing assistance: _____

_____

What can you afford to pay towards your counseling visits? $_____ per session

I authorize the release of information with respect to me or any of my dependents, which may have a bearing on the benefits payable for services rendered. I agree to pay all agreed upon charges for services not covered by insurance reimbursement.

Signature:_____ Date:_____

SAMARITAN COUNSELING CENTER HAWAI'I

Health & Wellness Survey

Name:_____

Date: _____

Part I: Health & Wellness (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle your answers)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Part II: Personal Resilience

How much do you agree with the following statements? (circle your answers)	Not true at all	Rarely true	Some-times true	Often true	Nearly always true
1. I feel in control of my life.	0	1	2	3	4
2. I get along well with my family, friends, and/or co-workers.	0	1	2	3	4
3. I have at least one close and secure relationship that helps me when I am stressed.	0	1	2	3	4
4. I can deal with whatever comes my way.	0	1	2	3	4
5. Past successes give me confidence in dealing with new challenges and difficulties.	0	1	2	3	4
6. I tend to bounce back after illness, injury, or other hardships.	0	1	2	3	4
7. I have a strong sense of purpose in life.	0	1	2	3	4
8. I believe I can achieve my goals, even if there are obstacles.	0	1	2	3	4
9. My faith/spirituality is a source of strength for me.	0	1	2	3	4

Samaritan Counseling Center Hawaii

Release of Information Consent Form (Optional)

For clients who choose to authorize SCCH to communicate with a family member, caregiver, doctor, agency, hospital, treatment facility, Court/Judiciary, or other third-party.

I, (Client Name) _____, hereby give my permission for the following releases of information by my therapist at the Samaritan Counseling Center Hawaii:

Name of Counselor: _____

Check the options that apply:

- ❑ To schedule, re-schedule, or confirm appointments
- ❑ To release information to ❑ or request information from ❑ the following person(s):

  Name, Title, Organization: _____

  Relationship: _____

  Mailing Address: _____

  Telephone: _____ Email: _____

The items covered by this release are checked below:

- ❑ Appointments and Cancellations
- ❑ Progress Notes and Treatment Plan
- ❑ Psychological Evaluation
- ❑ Other: _____

This information is being released for the following reason(s): ❑ Coordination of Care

- ❑ Other: _____

❑ I understand that this release may include information regarding drug and alcohol abuse and treatment, as well as psychological and psychiatric information.

❑ I understand that the information to be released is protected under state and federal laws that do not permit re-disclosure without my further consent.

❑ I understand that I may revoke this authorization at any time, except for information that has been disclosed as a result of this authorization prior to its revocation.

❑ This consent will expire _____ days from the date it is signed.

_____ _____

Signature of Client, Parent, Guardian, or Authorized Representative Date

_____ _____

Signature of Witness Date

Samaritan Counseling Center Hawaii

Credit Card Authorization Form (Optional)

For self-pay clients and clients who have a co-pay, co-insurance, or deductible

I authorize Samaritan Counseling Center Hawai'i to charge my credit card for health insurance co-payments, co-insurance, and/or and deductibles for my counseling sessions.

I understand that my information will be saved to file for future transactions on my account.

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____

EMAIL: _____

____ Send a receipt by email

____ Keep this credit card on file

NAME ON CARD: _____

AMOUNT: $_____ One-Time Payment

$_____ Recurring Payment per Counseling Visit

CARD NUMBER:_____ - _____ - _____ - _____

(MASTERCARD OR VISA ONLY)

EXPIRATION DATE: _____/_____ (MM/YY) Security/CCV#_____

SIGNATURE: _____ Date: _____

SAMARITAN COUNSELING CENTER HAWAI'I

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

PURPOSE OF THIS NOTICE

This notice tells you how we make use of your health information 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, known as Protected Health Information (PHI) is very important 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 Hawaii 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 April 14, 2003 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 Counseling Center Hawai'i. These changes could also effect 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.
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 charge to you.

USES and DISCLOSURES

Examples of how we may use or disclose your health information:

- To your physician or other healthcare provider who is also treating you.
- To anyone on our staff involved in your treatment program.
- To any person required by federal, state, or local laws to have lawful access to your treatment program.
- To receive payment from a third party payer for services we provide for you.
- To our own staff in connection with Samaritan Counseling Center Hawai'i'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.
- To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing at anytime. When you revoke an authorization it will only affect your health information from that point on.
- 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.

We will not use your health information in any of Samaritan Counseling Center Hawai'i'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.

Uses and Disclosures **Requiring Authorization**: For uses and disclosures beyond treatment and operations purposes we are required to have your written authorization (signed permission), unless the use or disclosure falls within one of the exceptions below. Like consents, authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

Uses and Disclosures **Not Requiring Consent or Authorization**: The law provides that we may use/disclose your PHI without consent or authorization in the following circumstances:

- **When required by law**: We may disclose PHI when a law requires that we report information about:
    - suspected abuse

- neglect or domestic violence
- suspected criminal activity
- in response to a court order

We must also disclose PHI to authorities who monitor compliance with these privacy requirements.

- **For health oversight activities**: We may disclose PHI for audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) to oversee the health care system.

- **To avert threat to health or safety**: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm. *For example, a plan to commit suicide or a homicidal act.*

- **For specific government functions**: We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

CLIENTS' RIGHTS

As a client of Samaritan Counseling Center Hawai'i **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. We will charge you $.10 per page for making these photocopies.
d. You have a right to a copy of Samaritan Counseling Center Hawai'i's 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 Samaritan Counseling Center Hawai'i's operations. This can go back as far as six years, but not prior to April 14, 2003.
k. If you request the accounting in "j" more than once in a 12 month period we may charge you a fee based on our actual costs of tabulating these disclosures.

CONTACT PERSON FOR INFORMATION OR TO SUBMIT A CLAIM

If you believe we have violated any of your privacy rights, or you disagree with a decision we made about any of your rights in this notice you may complain to us in writing to: ● Samaritan Counseling Center Hawai'i ● 1020 S. Beretania St., Honolulu, HI 96814.