CAROLE & RONALD KRIST
SAMARITAN
COUNSELING CENTER

INFORMATION ABOUT CENTER SERVICES

Welcome to Carole and Ronald Krist Samaritan Counseling Center, and thank you for choosing to use our services. It is important for you to be informed about the nature of psychotherapy, the policies and procedures governing the help you will receive, the fees for our services, and your rights as a client. In this package, there is a place for you to sign, indicating your general consent to treatment.

Psychotherapy: "Counseling" and "psychotherapy" (therapy) are often used interchangeably to indicate forms of psychological help that address various kinds of personal and family distress (e.g., depression, anxiety, marital conflicts). The goals of therapy range from the relief of symptoms to significant life change as one gains a better understanding of personal, interpersonal, and social circumstances. Therapy has been shown to have many benefits (e.g., better relationships, solutions to specific problems, significant reductions in feelings of distress). Progress in therapy depends on several factors including regular attendance, talking openly with your therapist, motivation, effort, and life circumstances. Results cannot be guaranteed. If your therapist believes counseling is not appropriate for your circumstances or that you should be referred elsewhere, you will be so informed. You and your therapist will decide together when your therapy is complete, but you may choose to withdraw at any time.

Psychological Testing: Psychological testing may be indicated before you begin therapy or at some point in the course of therapy. Your counselor can discuss these options with you. Psychological tests use samples of behavior in order to assess cognitive and emotional functioning. For more information, please see our testing consent form.

Psychoeducation: Psychoeducation refers to the education offered to individuals with a mental health condition and their families to help empower them to deal with their condition in an optimal way. The goal is for an individual or family member to gain a better understanding of the problem and to strengthen coping skills so they may contribute to their own health and wellbeing on a long-term basis.

Spiritual Integration: The Samaritan Center believes in a spiritually integrated approach to treatment, and we have expertise in including your faith/spiritual beliefs and practices as a part of the therapeutic process. It is our philosophy to work within your own belief system. Our therapists will not impose their personal beliefs upon you and will include discussion of spirituality/religion/faith in accordance with your expressed wishes.

Other Related Services: KSC also offers family and divorce mediation; topic specific psychoeducational groups; Irlen® diagnostic screenings and filters; and private academic tutoring.

Center Staff: The Center's clinical staff is comprised of licensed psychologists, licensed professional counselors, licensed social workers, licensed marriage and family therapists, and licensed speech therapists. We also have therapists-in-training working under the supervision of licensed therapists to obtain advanced degrees or to meet eligibility standards for licensure. All staff work within the standards and ethical guidelines of state licensing laws, professional associations, and the national accreditation standards of the Samaritan Institute.

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Client Name:_____

Your Rights as a Client

You have all of the rights established by the State of Texas governing clinical practices. These include:

- The right of consent to treatment,
- The right to be treated without discrimination,
- The right to be told in advance of all estimated charges, the cost of services and any limitations on length of services,
- The right to review information contained in your medical record,
- The right to an individualized treatment plan,
- The right to be informed of the use of any media devices such as one-way vision mirrors and tape recorders.
- The right to seek disclosure from your therapist about his or her qualifications,
- The right to requesting a different therapist,
- The right to end treatment at any time,
- The right to access the client grievance procedures,
- The right to have your clinical record kept private (see "Confidentiality" below),

You also have the right to have any tests, procedures, and recommendations explained to you in simple terms. You have the right to refuse such tests, procedures, or recommendations. **Initials:**_____

Confidentiality: What you tell your therapist will be kept confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, court order, or as part of the professional practice of this Center. We believe in an integrated approach to wellness and may share information about you to other medical and/or mental health providers within or outside of the Center in order to maximize your treatment outcomes. For further information please see our *Notice of Privacy Practices* and *Privacy Practices Acknowledgement.* Feel free to ask for clarification about anything you do not understand. **Initials:**_____

Fees and Payment: Information on Krist Samaritan Center published fees is provided separately. If you cannot afford the published fee, the Center may adjust your fee based on your income and number of family members. Proper documentation is required. Payment of your agreed upon fee is due at the time of your appointment. You may pay by cash, check or credit card. **Returned Checks and Rejected Credit Card Charges:** A **$35 fee** is charged on all checks returned for non-sufficient funds and rejected credit card charges. **Credit Card on File:** We ask that you keep a valid credit or debit card on file. This information will be kept in a secure, electronic file. The business office will charge this card for missed appointment fees, and returned check/credit card charges. If you wish to have this card charged for routine appointments, please request an Express Payment option. **Initials:**_____

Appointments and Cancellations: To avoid missed appointment fees, you are required to **cancel no later than 5:00 pm the prior business day.** The missed appointment **fee is $75**. This charge is not covered by insurance. If you receive fee assistance, you will be charged the fee you normally pay for a counseling session. If you miss an appointment two weeks in a row or twice in one month, you will lose your recurring appointment time. **Initials:**____

Weapons: A concealed or open carried weapon is forbidden on the Krist Samaritan Center property. Persons carrying concealed weapons must leave their weapons outside. Violation of this policy may include criminal penalties. **Initials:**_____

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Client Name:_____

Insurance and Other Third-Party Payments: If you wish to use insurance or other third-party coverage to pay for services, you are responsible for providing the Center with accurate and complete information. **As a courtesy,** the center will verify and send claims to your insurance company. **The Center does not guarantee that your insurance or other coverage will pay your claim.** You are responsible for knowing your insurance policy and benefits. You are responsible for the balance and for deductibles and co-payments required by your insurance or third-party payer. **Initials:**_____

Insurance & Confidentiality: You should be aware that your contract with your health insurance company requires that the Center provide the company with information relevant to the services you receive. We make every effort to release only the minimum information necessary for the purpose requested. **Initials:**_____

Legal Proceedings: The staff of the Center **does not provide testimony in legal proceedings**. However, if you choose to subpoena your therapist or your records, you agree to pay for any required preparation time, for your therapist's time out of the office, and for travel at a charge that may equal or exceed the Center's hourly rate. **Initials:**_____

Emergencies: The Center does not provide "emergency services". If you have an urgent concern, we try to schedule an appointment as soon as possible. If you have a critical emergency, contact one of the following: Center on-call staff 281-480-7554 or the Crisis Hotline (713) 970-7520. After-hours messages can be left on the Center's voice-mail system, but do not leave an urgent message since these messages may not be reviewed until the next business day. **Initials:**_____

Grievances: You are encouraged to talk first with our staff about any concerns you may have about our services; however, if you prefer, you may file a formal grievance with the Clinical Director within 45 days of the time you become aware of a problem. We will investigate and attempt to resolve it within 30 days. If the problem is not resolved, the Center's Executive Director will investigate and prepare a written decision within 10 days. You may appeal the Executive Director's decision directly with the Center's Board of Directors within 14 days. The decision from the Board of Directors is final. You will not be threatened or penalized in any way for presenting your concerns informally by talking with staff or formally by filing a grievance. **Initials:** _____

Consumer Complaint Hot-Lines: Licensed Professional Counselors and Licensed Marriage and Family Therapists (800) 942-5540; Social Workers (800) 232-3162; Licensed Psychologists (512) 305-7709; Pastoral Counselors (703) 385-6967. Or by mail: Texas Department of State Health Services Office of Consumer Services and Rights Protection Mail Code 2019 P.O. Box 12668 Austin, TX 78711-2668 1-800-252-8154. You will not be retaliated against for any reports you may make.

Printed Name:_____Signature:_____Date: _____

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PERSONAL INFORMATION FORM

Complete one form for each person that will be participating in services.

First Name_____ Middle Initial _____ Last Name_____

Birth Date_____/_____/_____ Age _____ Gender Identity: □ Male □ Female □ LGBTQ+ □ Other

Address_____City_____State_____Zip_____

County_____Email Address_____

Home Phone_____Work Phone_____Cell Phone_____

Which ONE number may we use to leave messages and appointment reminders? □ Home? □ Work? □ Cell?

May we also contact you by □ Email ? □ Text? □ Mail?

Emergency Contact: Name_____Phone Number _____

If person receiving services is a child, Other Parent's phone number _____ □ Mother □ Father

If applicable, an alternative mailing address for billing statements:

Address_____City_____State_____Zip_____

Primary Care Physician or Psychiatrist:_____Phone number: _____

Military Status: □ Current Service Member □ Veteran □ Family member □ N/A
If you are a Military Family Member, what is your Relationship to Veteran or Service Member: _____

Ethnicity: □ African-American □ Anglo/Caucasian □ Asian □ Hispanic/Latino □ Native American □ Other

Are you affiliated with a church, synagogue, mosque, or other? □ Yes □ No Affiliation: _____

Referral Source: □ Friends/Family □ Past/Current Client □ Insurance □ Website □ Hospital □ Counselor □ Court
□ Church/Name _____ □ Work/Name _____
□ Doctor/Name _____ □ School/Name _____
□ Social Service/Name _____ □ Other/Name _____

Annual household income: $_____ Number of people living in household:_____

If you are paying by insurance, please fill out the following

Primary Insurance:_____Member ID_____Group # _____ Is this a Medicare plan? □ Yes □ No

Policy Holder Name:_____Policy Holder Date of Birth _____

Secondary Insurance:_____Member ID_____Group #_____Is this a Medicare plan? □ Yes □ No

Policy Holder Name:_____Policy Holder Date of Birth _____

Will someone other than you be responsible for payments? □ **Yes** □ **No** If Yes, please complete the following:

Organization (if applicable):_____

Person: First Name_____Last Name_____Phone#_____

Address_____City_____State_____Zip_____

Are your behavioral health benefits paid through an arrangement with a separate company? □ No □ Yes

Insured or Responsible person's signature: I consent and authorize the Krist Samaritan Center to release medical or other supporting information necessary to process my insurance claims and/or for collecting payment from the above person/organization. I authorize payment of medical benefits to Krist Samaritan Center. *I understand that I am responsible for all deductibles and co-pays. I understand that I am responsible for 100% of my charges if I am a Private Pay client. I understand all charges and co-pays are due at time of service. I understand that I must inform the Krist Samaritan Center if my insurance is a **Medicare or Medicaid** plan and that if I do not, I am waiving my rights to use my **Medicare or Medicaid** insurance plan and I will be responsible for all charges and co-pays.*

Printed Name:_____Signature:_____Date: _____

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NOTICE OF CLIENT FINANCIAL ESPONSIBILITY

Thank you for choosing us as your trusted provider. We are committed to providing you and your family with quality and affordable health care in an environment of trust and respect. Our business office has provided this fee policy, consistent with current health care industry practices, to ensure that all clients are adequately informed of their financial rights and responsibilities. Please read carefully and sign and initial in the spaces provided. If you have any questions, our staff will gladly address them. Thank you.

PAYMENT POLICY

1. ***Client Responsibility*.** You are responsible for payment for all services rendered.
2. ***Payment at Time of Service.*** Payment is due at the time services are rendered.
3. ***Credit Card on File.*** We ask that you provide a valid credit card or debit card to be kept in a secure, electronic file. The business office will charge this card for missed appointment fees. You may also sign up for Express Payment to automatically pay for your appointments with this credit card. Information on Express Payment is below.
4. ***Missed Appointment Fees***. **The missed appointment fee is $75**. This charge is not covered by insurance. If you receivefee assistance, you will be charged the fee you normally pay for a counseling session. If you miss an appointment two weeks in a row or twice in one month, you will lose your recurring appointment time.
5. ***Cancellation Policy*.** To avoid missed appointment fees, clients are required to cancel no later than 5:00 pm the prior business day.
6. ***Past Due Balances*.** Any past due balance must be paid prior to the next appointment.

Responsible party initials: _____

INSURANCE

1. ***Accepting Insurance*.** We participate in many insurance plans and file insurance as a courtesy and convenience to you. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. ***Claims submission*.** While your insurance benefit is a contract between you and your insurance company, we will submit your claims and make reasonable efforts to obtain payment from the insurance company. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
3. ***Co-payments*.** All health insurance co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.
4. ***Deductibles***. If the insurance deductible has not yet been met, you are responsible for full and timely payment until such time as the deductible has been met.
5. ***Non-covered Expenses*.** Some evaluations, assessments or treatment expenses may not be covered by insurance. **If insurance does not cover these, you are responsible for full and timely payment.**

Responsible party initials:_____

EXPRESS PAYMENTS

For your convenience, if you wish the Krist Samaritan Center will automatically charge your credit card for each appointment. Please indicate below if you would like this Express Service.

_____I would like the Krist Samaritan Center to run my credit card each time I receive treatment and services, for my convenience.

_____If you would *not* like to receive emails and newsletters from Krist Samaritan Center, please initial here.

_____ _____

Financially Responsible Party Signature Date

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PRIVACY PRACTICES ACKNOWLEDGEMENT

Client Name:_____

Please read and complete.

I have reviewed the *Notice of Privacy Practices* and understand and acknowledge that:

- Krist Samaritan Center's *Notice of Privacy Practices* is available to view at any time, and I may request a copy of the notice at any time.
- If I have any questions about the notice, I should ask my therapist, or Krist Samaritan Center's Privacy Officer, for clarification
- Krist Samaritan Center may change or modify its *Notice of Privacy Practices* at any time, and I have the right to obtain a revised *Notice of Privacy Practices* by calling the office and requesting a revised copy be mailed to me, or asking for one at the time of my next appointment.

I understand that State and/or Federal laws permit or require the use or disclosure of my private health information without my consent or authorization in the following circumstances:

- **Child Abuse:** If we have reason to believe that a child has been, or may be abused, neglected, or sexually abused, we must make a report within 48 hours to the Texas Department of Protective and Regulatory Services.
- **Adult Abuse:** If we have reason to believe that an elderly or disabled person has been or may be abused, neglected, or exploited, we must immediately report this to the Texas Department of Protective and Regulatory Services.
- **Health Oversight**: If a complaint is filed against us with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Judicial or Administrative Proceedings:** We can share private health information about you in response to a court or administrative order.

_____ _____

Signature of Parent, Guardian or Legal Representative Date Description of legal representative's authority

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AGREEMENT & CONSENT FOR ASSESSMENT FORM

Client Name_____

Please read and complete ONE form for each couple and/or family.

A growing body of research suggests that routine and frequent use of outcome questionnaires is associated with better treatment outcomes. Information from the questionnaires help the clinician and client monitor improvement and make adjustments in the treatment plan as necessary. For this reason, you may be asked to complete a brief questionnaire as part of your treatment. Please respond as honestly as possible because this will help your doctor or therapist evaluate if the treatment is effective for you.

Your therapist subscribes to an outcomes measurement service (The Center for Clinical Informatics) that provides automated scoring and interpretation of the outcome questionnaires. The service will help you and your therapist monitor your improvement.

Please be assured that your personal information is kept strictly confidential. The questionnaires remain anonymous, identified only by an ID number that is assigned by your therapist. The only information which is disclosed is an ID number, the questionnaire, your age, gender, diagnosis, general health status, and whether you have received mental health treatment previously. The outcomes measurement service center and qualified academic researchers may use the data to investigate ways to improve treatment outcomes. These research professionals do not have access to any information that could be used to personally identify you as an individual receiving treatment, nor do they have any access to your confidential medical records.

You are free to decline to complete the questionnaires. Refusal to complete the questionnaires will not affect your treatment or insurance coverage in anyway.

I **do** **do not** consent for treatment progress to be evaluated and monitored using an evidence-based outcome measurementtool that will guide the therapist's clinical decisions regarding my/my child's treatment. (please check one)

_____

Counseling Participant or Legal Representative Date

_____

Signature of Parent, Guardian or Legal Representative Date

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AGREEMENT & CONSENT FOR TREATMENT FORM

Client Name_____

Please read and complete.

I have read and understood the information contained in the *Information About Center Services* document. In signing this *Client Agreement and Consent for Treatment Form*, I acknowledge that:

- I do hereby consent to evaluation and treatment by Krist Samaritan Center.
- I voluntarily enter into the treatment process.
- I may withdraw from treatment at any time unless treatment is court ordered.
- I am 18 years of age or over and have not been declared incompetent by a court of law, or
- I am the parent/legally-appointed guardian or other authorized representative of the client to be treated, if such client is 17 or younger, or
- Although under 18 years of age, I am legally empowered to consent to treatment per the conditions outlined in the Texas Family Code.
- I acknowledge that I am financially responsible to the Center as described in the Client Information Form for all services and treatment rendered to the client named in this consent.
- I have received a copy of my rights as a client in the State of Texas included in *Information About Krist Samaritan Center Services.*

I further acknowledge the following:

- I have been informed that my therapist is a ☐ Staff Therapist ☐ Resident Therapist

I also acknowledge the following:

- De-identified information, such as general demographics, number of sessions, and treatment outcomes, may be reported to foundations that financially support Krist Samaritan Counseling Center. I understand that my Protected Health Information (PHI) will not be shared with these entities.

I acknowledge that the information contained in the Agreement and Consent for Treatment Form has been made available to me, explained to me, or read by me and that it was presented in clear non-technical language. My signature affirms that the information is understood by me and enables me to make an informed voluntary consent to this treatment.

Please List Participants:

_____ _____
Counseling Participant or Legal Representative — Description of legal representative's authority

_____ _____
Counseling Participant or Legal Representative — Description of legal representative's authority

_____ _____
Counseling Participant or Legal Representative — Description of legal representative's authority

_____ _____
Counseling Participant or Legal Representative — Description of legal representative's authority

***If the participant is a minor: I give permission for the following minor child(ren) to receive treatment and to receive treatment, without a parent or guardian present.**

_____ _____
Print Minor's Name — Print Minor's Name

_____ _____
Print Minor's Name — Print Minor's Name

_____ _____
Signature of Parent, Guardian or Legal Representative Date — Description of legal representative's authority

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HEALTHCARE COORDINATION FORM

Client Name: _____

Client: Research indicates there is a close relationship between physical and mental health and that better treatment outcomes will be achieved if your therapist and your primary care physician coordinate your care. Many physical complaints are rooted in psychosocial issues and physical symptoms can be signs of mental stress. This coordination and consultation is especially important if you are on medication. Medication may have side effects that could affect your mood, ability to concentrate and fully participate in therapy. This form is to give your consent to consult with your psychiatrist, primary care physician, nurse practitioner, or other providers to ensure you receive the best possible care from the Krist Samaritan Center. Most insurance companies require coordination of care with all appropriate behavioral health and medical providers.

Please check one:

_____I give permission for you to coordinate my care with my other healthcare providers

_____I do not have a Primary Care Physician or see any other doctors at this time

_____I do not give permission for consultation with other providers at this time

Physician Name: _____ Clinic Name: _____

Telephone:_____ Fax number: _____

Physician Name: _____ Clinic Name: _____

Telephone:_____ Fax number: _____

Physician Name: _____ Clinic Name: _____

Telephone: _____ Fax number: _____

_____

Client (or guardian) signature Date

_____

Therapist name printed

PHYSICIAN/PROVIDER: You have been identified as this client's medical provider. We want to inform you that your patient was seen for outpatient psychotherapy at the Krist Samaritan Center and has authorized us to consult with you as necessary regarding their treatment. **Please feel free to contact us if you would like additional information.**

Please acknowledge below that this client is a patient of yours and that you will be available for consult.

1. _____ We have no record of having provided recent medical care to the client.
2. _____ This is our patient and we will be available for consult if needed.

Comments/Medication:

Physician's signature (or official representative) Date

Please Return by fax: 281-480-4193 Or mail to:
Krist Samaritan Counseling Center 16441 Space Center Blvd, Suite C-100, Houston, TX 77058
For Krist Samaritan Center Office Use Only: Date faxed to Physician_____initials _____