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.

Parents who bring children to the Samaritan Center are considered the responsible party. This means that all copays need to be paid at time of visit.

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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Parent Information

Child Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

_____

Phone: _____ Cell: _____

E-mail: _____

Place of Employment: _____

Work #: _____ Ext: _____

Non-Custodial Parent: _____

Non-Custodial Address: _____

_____

Child's School: _____

People In Household:

Names:	Relationship:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Insurance Company: _____

ID#: _____

Typical Visitation Arrangements:

_____

_____

_____

_____

Custody Arrangements:

☐ Joint (mother/father)

Explain: _____

_____

_____

☐ Sole – Mother ☐ Sole – Father

☐ Other: _____

Legal Arrangements:

☐ Joint (mother/father) ☐ Sole – Mother ☐ Sole – Father

☐ Other: _____

Religious Affiliation:

☐ Catholic ☐ Baptist ☐ Jewish ☐ Other

☐ Reformed ☐ Unitarian ☐ Lutheran ☐ None

☐ Pentecostal ☐ Episcopalian ☐ Presbyterian

☐ Methodist ☐ Community Church

☐ Church: _____

Reason for seeking treatment:

_____

_____

_____

Do you have concerns about abuse? ☐ yes ☐ no

☐ physical ☐ emotional ☐ sexual

Explain: _____

_____

Does your child ever think of committing suicide? ☐ yes ☐ no

Explain: _____

_____

Do you have concerns that your child is using and/or abusing alcohol or drugs? ☐ yes ☐ no

Explain: _____

_____

_____

_____

Medical Information:

Primary Care Physician: _____

Address: _____

_____

Phone: _____

Date of last physical exam: _____

Allergies: _____

Has your child ever been hospitalized? ☐ yes ☐ no

When and for what reason? _____

_____

_____

_____

Is your child presently on medications? ☐ yes ☐ no

Name and Dosage: _____

_____

_____

_____

_____

_____

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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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Authorization for Treatment of a Minor

PLEASE FILL OUT IN INK

I, _____, hereby certify that I am the parent/legal guardian of the minor child_____ Date of Birth _____ and that I have authority to give consent for his/her treatment. I request and permit that said child shall receive treatment at the Adirondack Samaritan Counseling Center, 15 Boulevard, Hudson Falls, NY 12839 and accept financial responsibility therefore. I understand that this consent may be withdrawn upon presenting 30 day written notice.

Parent: _____ Date: _____

Witness: _____ Date: _____

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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 child's age?
   ☐ 0-9 ☐ 10-18

2. Is your child male or female? ☐ Male ☐ Female

3. What is your child's racial background?
   ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander
   ☐ Black/African-American ☐ White/Caucasian

4. Is your child of Spanish or Hispanic origin or ancestry? ☐ yes ☐ no

5. What is the highest grade your child has completed in school?
   ☐ K-5 ☐ 6-8 ☐ 9-12

6. How many adults live in your household?
   ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 or more

7. How many children live in your household?
   ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 or more

8. 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.

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