



For Office Use Only	
Date of Initial Visit	_____
Acct Number	_____ Clinician _____
Scanned	_____ Received _____
Insurance Entered	_____

2022 15th Ave., Columbus, GA 31901 • Shawmut United Methodist Church, 2301 31st Street, Valley, AL 36854

A S A M A R I T A N C E N T E R

## COUNSELING CENTER NEW CLIENT INFORMATION

Please complete this entire form. Much of this information is necessary in order to file EAP, CAP and/or insurance.

**How did you learn about the Pastoral Institute?** (please check all that apply)

- Pastor/Church     Friend     Physician     Employer     Family     EAP/Insurance  
 Counselor     Television     Newspaper     Radio     Billboards     Web site     Magazine  
 Pastoral Institute Counselor     Current/Previous Pastoral Institute Client

Name \_\_\_\_\_ Date of Birth (DOB) \_\_\_\_\_  
 Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security # \_\_\_\_\_ Race \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell phone/pager # \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ How Long? \_\_\_\_\_  
 Religion \_\_\_\_\_ Local Affiliation \_\_\_\_\_  
 Education Completed \_\_\_\_\_ Name of School Currently Attending (if applicable) \_\_\_\_\_  
**Spouse** (if applicable): Name \_\_\_\_\_ DOB \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Education \_\_\_\_\_ Religion \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ How Long? \_\_\_\_\_  
**Marital Status:** Single \_\_\_\_\_ Live-In \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
 Date of Marriage or Re-marriage \_\_\_\_\_  
**Children's Name(s) and Age(s)** \_\_\_\_\_  
 \_\_\_\_\_

### Client Family History

Mother's Name and Age \_\_\_\_\_ Education/Occupation \_\_\_\_\_  
 Number of times married \_\_\_\_\_  
 Father's Name and Age \_\_\_\_\_ Education/Occupation \_\_\_\_\_  
 Number of times married \_\_\_\_\_  
 Are your parents...  
 \_\_\_\_\_ Separated? If yes, please indicate your age at the time. \_\_\_\_\_  
 \_\_\_\_\_ Divorced? If yes, please indicate your age at the time. \_\_\_\_\_  
 \_\_\_\_\_ Deceased? If yes, please indicate your age at the time. \_\_\_\_\_  
 \_\_\_\_\_ Remarried? If yes, please indicate your age at the time and your step-parent's name(s). \_\_\_\_\_  
 \_\_\_\_\_

Birth Order: I was born the \_\_\_\_\_ of \_\_\_\_\_ children.

**Mental Health Information**

Please tell us what you are experiencing and/or what has happened to cause you to seek counseling. (Use back of page if needed.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please tell us about any previous mental health care you've received and dates \_\_\_\_\_

\_\_\_\_\_

**General Health Information**

Physician \_\_\_\_\_

*Physician First Name*

*Physician Last Name*

Are you presently under the care of a physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

Physician's Address \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Dates of surgical/invasive procedures \_\_\_\_\_

Amount of alcohol consumed daily \_\_\_\_\_

List medication(s) taken regularly \_\_\_\_\_

Do you exercise? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how often? \_\_\_\_\_

**Other Information**

**Emergency Contact:** Name \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

**Financial and Insurance Information**

If the person responsible for payment is the same as the client, write SAME and go to Primary Insurance section.

Name of Person Responsible for Bill \_\_\_\_\_  
Relationship to Client \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_

**Primary Insurance. (This will be the insurance company that we file the claim with first.)**

Name of Policy Holder \_\_\_\_\_  
Policy # of Insured \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_ Insured's Employer \_\_\_\_\_  
Insurance Authorization # (if applicable) \_\_\_\_\_

**Secondary Insurance (if applicable)**

Name of Policy Holder \_\_\_\_\_ Policy # of Insured \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_ Insured's Employer \_\_\_\_\_  
Insurance Authorization # (if applicable) \_\_\_\_\_

In order to file your insurance, we must have a copy of your insurance card.

**Authorization to Release Information and Assignment of Benefits**

I hereby authorize the Pastoral Institute, or any member of its staff, to release to my insurance company or companies any information acquired in the course of my examination or treatment.

You are hereby authorized to pay to the Pastoral Institute, Inc., Basic Benefits and/or Major Medical Benefits for medical expenses, or to include their name on the check payable to me for medical expenses otherwise payable to me for treatment.

In making this assignment I understand and agree any unpaid balance not covered by this policy will be paid by me. I understand that filing of insurance does not guarantee payment.

\_\_\_\_\_  
Client Name (Printed)

\_\_\_\_\_  
Client Signature  
(or Parent's Signature if Client is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Pastoral Institute Witness Initial      Date

This form must be signed in order for the Pastoral Institute to file charges with your insurance company.



## FINANCIAL POLICY AND AGREEMENT

The following guidelines have been established in order to clarify any questions:

If you have health insurance, we will be glad to assist you in determining coverage, filing claims and seeking reimbursement. Please see our Business Office regarding any insurance that we will be filing on your behalf. We cannot guarantee insurance reimbursement. All fees charged are the direct responsibility of the client.

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is your responsibility to follow up with your insurance company to make sure they pay your claims.

If your insurance coverage for mental health services requires pre-authorization, you must call for authorization. If you have not called, please call for authorization immediately. Your insurance company will not pay for services that have not been authorized.

If your company or church has an Employee Assistance Program (EAP) or a Congregational Assistance Program (CAP) through the Pastoral Institute, it will pay a set amount for a specified number of sessions.

Payment for co-pays and deductibles is due at the time service is rendered. Payments may be made by cash, check, debit cards or credit cards. All returned checks are forwarded to Check Care for collection. Check Care adds an additional fee for collection.

While the Pastoral Institute understands that some blended family situations are complicated, we cannot and will not become entangled with various arrangements set forth in Divorce Decrees and the like. Therefore, payment for any and all services rendered will be expected from the guardian that escorts the patient to his/her appointments.

Accounts that become more than 90 days past due may be forwarded to our collection agency.

If your insurance company does not pay within 90 days, the unpaid balance is due from you.

Our policy is to bill for any appointment canceled without 24-hour advanced notice.

### FINANCIAL AGREEMENT

I understand the above financial arrangements. I also understand I will receive a statement each month if there is a balance due from me. I agree that statements are correct unless questioned within 30 days in writing or telephone contact with the Pastoral Institute Business Office.

\_\_\_\_\_  
Client's Name (Printed)

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Pastoral Institute Witness Initial

\_\_\_\_\_  
Date



## COUNSELING, CONFIDENTIALITY AND PRIVACY PRACTICE AGREEMENT

I am aware that the practice of counseling is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment by the Pastoral Institute's staff members.

I agree to collaborate with my therapist and other appropriate professional staff members of the Pastoral Institute for the purpose of assessment and evaluation of my current situation and to work together to identify appropriate goals and methods of achieving them.

I understand that over the course of therapy, whatever assessments, tests or other clinical care that is recommended will be fully explained to me and that I have the option to accept or reject such care.

I understand that the Pastoral Institute is committed to quality care. I may contact the Director of the Counseling Center regarding any questions about my therapist or concerns about the quality of my care.

I understand that the Pastoral Institute may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and any call pertaining to my clinical care.

**I have read the above and give my consent to the counseling process. I have also read and understand the Pastoral Institute's statement regarding the limits of confidentiality.**

**I have had an opportunity to review the Pastoral Institute's Notice of Privacy Practices.**

I have had an opportunity to ask questions to seek any clarification I needed about these important materials.

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Client's Name (Please Print)

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Client Signature  
(or Parent's Signature if Client is a minor)

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Date

---

Pastoral Institute Witness Initial

Date



## EMAIL CONFIDENTIALITY RELEASE AGREEMENT

I \_\_\_\_\_, understand that CONFIDENTIALITY OF E-MAIL COMMUNICATIONS WITH MY THERAPIST CANNOT BE GUARANTEED.

For example,

- E-mails go through several intermediate stations before reaching their destination. Someone at any point along the line could access the email and even store the message contained in it.
- E-mails may remain stored in various places of a computer system and could surface at a later time.
- Computers, particularly those on DSL lines, are vulnerable to electronic eavesdropping.

Knowing the above information and considering other possibilities not yet known that could further jeopardize confidentiality, I give my permission to my therapist to respond to my e-mails according to his/her professional judgment.

I further agree that I will not attempt to extend therapy via e-mails, but only use it to conduct business of information sharing such as canceling or securing an appointment. Any therapeutic issues I will handle either during the therapeutic face to face meeting or as appropriate, by telephone in emergencies. Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.

\_\_\_\_\_  
Client's Name (Please Print)

\_\_\_\_\_  
**Client Signature**  
(or Parent's Signature if Client is a minor)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Pastoral Institute Witness Initial      Date**

# THE PASTORAL INSTITUTE

A Samaritan Center

## RELEASE OF INFORMATION CONSENT FORM

I, \_\_\_\_\_ (Record# \_\_\_\_\_) hereby give my permission for the following releases of information by my therapist at the Pastoral Institute Counseling Center:

Name of therapist: \_\_\_\_\_

Check the options that apply:

- To write or call the referring persons as a professional courtesy to let them know that I came for my appointment  
 To release information to  or request information from  the following person/s:

Name of agency, hospital, doctor, or therapist: \_\_\_\_\_

Mailing address: \_\_\_\_\_

_____	Street	_____	City	_____	State	_____	Zip
_____	Telephone	_____	Fax				

The items covered by this release are checked below:

- Intake Assessment       Psychological Evaluation  
 Treatment Plan       Discharge Summary  
 Psychiatric Evaluation       Other: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

This information is being released for the following reasons:

\_\_\_\_\_

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

This consent will expire 180 days from the date it is signed.

PHI(Protected Health Information), once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA.

I understand that that I have the right to receive a copy of this release if requested.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian, or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

### REVOCATION OF CONSENT

In revoking consent, I understand that this does not affect any of the ways you used my protected health information while you still had my permission to do so.

\_\_\_\_\_  
Signature of Witness      Date

\_\_\_\_\_  
Signature of Client      Date



## NOTICE OF THE PASTORAL INSTITUTE'S PRIVACY PRACTICES

### For Your Records - Client Copy

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 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 Georgia 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 the Pastoral Institute, Inc. 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 charge to you.

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

We may use or disclose your health information...

1. To your physician or other healthcare provider who is also treating you with your written authorization.
2. To Pastoral Institute 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 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 affect your health information from that point on.
7. 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 the time. In so doing, we will only use or disclose the aspects of your health information that are necessary to respond to the emergency.
8. To appropriate authorities under Georgia Law in the following circumstances: Imminent Danger to you or others, Child Abuse or under Court Order.
9. To help us carry out health care operations such as appointment reminders, insurance items and calls pertaining to your clinical care.

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 Pastoral Institute, Inc., 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 \$0.10 per page for making these photocopies.
- 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 that, 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: Sandy Harris, Compliance Officer, Pastoral Institute, 2022 15th Avenue, Columbus, GA 31901. Phone (706) 649-6362 Fax (706) 649-6338
- 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.

## **PASTORAL INSTITUTE CONFIDENTIALITY STATEMENT**

Welcome! We are glad you have chosen the Pastoral Institute. Below is some information written for you to clarify confidentiality in the counseling process.

### **CONFIDENTIALITY**

We commit to keep confidential what you say in the counseling process. The following are the only exceptions:

1. Supervision/Case consultation. A part of our commitment to providing quality care for you is to regularly consult with other professionals on staff. Your identity is kept confidential during these consultations. From time to time, we may also audio or video tape your sessions, but only after receiving your written permission. The taping would be used for our professional consultations and in counselor training.
2. Requirements by law. The records from your counseling are confidential and cannot be released to anyone without your written consent except under the following conditions provided by the law:
  - Imminent Danger – The law states that if we judge you to be a danger to yourself or others, we are required to take action to prevent harm from occurring to you or others.
  - Child Abuse – We are required by law to report all cases of actual or suspected physical, emotional, or sexual abuse or neglect of children to the Department of Family and Children Services.
  - Disabled Adult Abuse – We are required by law to report all cases of actual or suspected physical, emotional, or sexual abuse or neglect of disabled adults to the Department of Family and Children Services.
  - Court ordered

We hope this information is helpful to you. Please feel free to ask questions.

2022 15th Avenue  
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(706) 649-6500

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