



## CLIENT CONSENT FORM

### Philosophy of Integration

Our informed consent statement includes the following reference to the Samaritan's philosophy of integration. The Center is a faith-based/spiritually centered/affirming organization and we have expertise in including client's faith/spiritual beliefs and practices as a part of the therapeutic process. It is our philosophy to work with in the belief system and the spiritual and cultural belief of the client. The Samaritan's therapists do not impose their personal beliefs, values, or spirituality/theological views upon the client, and include discussion of spirituality/religion/faith/and identification of their culture and ethnicity according to the expressed preference of the client.

### Confidentiality

The information that you provide the Samaritan Counseling Center, will be kept confidential. This information will be released to an outside agency or professional only when you sign an "Authorization for Release of Information," form stating that you have full knowledge of the nature of the information that is being released, the purpose for which it is intended to be used, and the name of the qualified person or agency who will receive this information.

The only exception to this would be in those rare occasions when:

1. You are considered to be dangerous to yourself or others.
2. There is known or suspected child abuse that has not been addressed.
3. An order to release records by a court of law (including subpoena) has been received.
4. A medical emergency

You hold harmless the Samaritan Counseling Center, its agents and employees, for any loss, costs or damages allegedly sustained by you or your ward because of the release of information under the above listed circumstances.

### Consent for Treatment

In order to provide you with mental health treatment, the Samaritan Counseling Center, requires your authorization for treatment. By signing below, you or your guardian are indicating that you are agreeing to treatment and authorizing the Samaritan Counseling Center therapist and other personnel to provide you with mental health services.

### Payment Agreement

Payment is required at the time of service unless previous arrangements have been made. I agree to pay any interest, and all fees, including all reasonable attorney legal, reasonable collection fees and court cost incurred regarding my account(s). I understand that I am responsible to make a payment every 30 days. I agree that the Samaritan Counseling Center and any agent of the Samaritan Counseling Center may use various types of technology and electronic methods of communication to collect the balance of my account, to include texting, email, voicemail, and automated calling equipment.

It is your responsibility to determine if the services requested and providers are covered by your insurance plan. You are responsible for any co-payments, co-insurance, and non-covered services as determined by your insurance company. If you lose coverage or change insurance plans, you must notify the Samaritan Counseling Center immediately. The Samaritan Counseling Center files insurance claims as a courtesy to our clients. In return, we ask that you authorize your insurance company to make payments directly to the Samaritan Counseling Center. If you do not wish for the Samaritan Counseling Center to file with your insurance, you will be required to pay for services at the time of service.

**In signing below, I hereby authorize insurance benefits to be paid directly to the Samaritan Counseling Center and understand I am financially responsible for all non-covered charges. I also authorize the Samaritan Counseling Center to release to my insurance company any information or medical records required/requested to process this claim.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_