SAMARITAN COUNSELING CENTER
1803 OREGON PIKE
LANCASTER, PA 17601
717-560-9969

APPOINTMENT DATE/ TIME:_____

THERAPIST:_____

CHILD AND ADOLESCENT REPORT FORM

This questionnaire asks you to respond to a series of questions about your child and your family. Please complete these forms as best you can. We will have the opportunity to discuss them in detail at the time of your child's appointment.

Today's Date | Child's Name | Date of Birth | Age | Grade

Person Completing Form | Your Relationship to Child

Mother's Name | Date of Birth | Work Phone | Home Phone | Cell Phone

Address | City | State | Zip

Father's Name | Date of Birth | Work Phone | Home Phone | Cell Phone

Address | City | State | Zip

If your child is 14 years or older, please provide their cell phone:_____

Is this your biological, adopted, step, foster, other_____child?

Are the child's legal parents married? ❒ No ❒ Yes
Is there a legal custody agreement/order? ❒ No ❒ Yes – **Please provide at first session.**
If there is a legal custody agreement/order:
In whose physical custody is this child? ❒ Mother ❒ Father ❒ Both ❒ Other*
In whose legal custody is this child? ❒ Mother ❒ Father ❒ Both ❒ Other*
(Note: consent must be obtained from all persons with legal custody prior to meeting with your child)

*If other, Name | Work Phone | Home Phone | Cell Phone

Address | City | State | Zip

Health Insurance Company:_____

ID Number:_____ Group Number:_____

Name of and Child's Relationship to the Policy Holder:_____

Date of Birth of the Policy Holder:_____ Employer of the Policy Holder:_____

Who Will Be Responsible For Payment?_____ Who Referred You To Samaritan Center?_____

What are your concerns about this child? What are the difficulties/problems that cause you to seek help at this time?_____

CHILD'S DEVELOPMENTAL HISTORY

Pregnancy

Mother's age at the time of pregnancy with this child_____ Length of pregnancy in months (or weeks) if known_____

Were any medications used during pregnancy? ❒ No ❒ Yes; please specify._____

Did the mother smoke cigarettes during this pregnancy? ❒ No ❒ Yes; please specify average number per day._____

Did the mother drink alcohol during this pregnancy? ❒ No ❒ Yes; please specify what type of alcohol and how much was consumed per day_____

Did the mother use any type of drugs during this pregnancy? ❒ No ❒ Yes; please specify what type of drugs and amount used per day_____

Pregnancy complications (check all those that apply):

❒ bleeding ❒ high blood pressure ❒ toxemia
❒ infections ❒ diabetes ❒ other, please explain:_____

Delivery

Type of labor: ❒ spontaneous ❒ induced due to_____

Type of birth delivery: ❒ normal ❒ breech ❒ Cesarean section

Duration of labor:_____hours

Were there any problems with labor and/or delivery? ❒ No ❒ Yes (please explain):_____

Perinatal History

Baby's weight at birth:_____pounds_____ounces Baby's length at birth:_____inches

Any problems or comments regarding this child when he/she was a newborn? ❒ No ❒ Yes; please specify._____

Infancy and Early Childhood

Colicky	❒ No	❒ Yes, please specify_____
Feeding problems	❒ No	❒ Yes, please specify_____
Sleeping problems	❒ No	❒ Yes, please specify_____
Restless	❒ No	❒ Yes, please specify_____
Active	❒ No	❒ Yes, please specify_____
Did not enjoy cuddling	❒ No	❒ Yes, please specify_____
Excessive fearfulness	❒ No	❒ Yes, please specify_____
Excessive shyness	❒ No	❒ Yes, please specify_____
Strong reluctance to separate from mother	❒ No	❒ Yes, please specify_____
Headbanging	❒ No	❒ Yes, please specify_____
Accident prone	❒ No	❒ Yes, please specify_____
Uncoordinated	❒ No	❒ Yes, please specify_____

Are there other problems or comments regarding this child's infancy and early childhood development? If so, please explain:_____

Child's approximate age when she/he began: walking_____months

talking (single words) _____months talking (short sentences--2+ words) _____years

toilet training: daytime_____years nighttime_____years

Does this child have wetting accidents in bed currently? (day/night?) ❒ No ❒ Yes

Does this child have soiling accidents currently? (day/night) ❒ No ❒ Yes

Did this child previously have a problem with wetting or soiling? (day/night?) ❒ No ❒ Yes; please explain._____

_____

Overall, do you feel this child developed at a ❒ slower rate ❒ average rate ❒ rapid rate

Please explain:_____

_____

Any special health considerations? Please explain. _____

ADDITIONAL INFORMATION

_____

Child's Pediatrician Phone

_____

Address City State Zip

Have you notified the child's physician of your appointment here? ❒ No ❒ Yes

Have you discussed this child's problems with the physician? ❒ No ❒ Yes

Current health: ❒ poor ❒ fair ❒ good ❒ excellent

Child's present height_____feet_____inches Child's present weight_____pounds

Is this child in any way physically ill at this time? ❒ No ❒ Yes; please explain _____

_____

Does this child have any medication allergies? ❒ No ❒ Yes; specify medication(s) and reaction(s):_____

_____

Does this child have any other allergies? ❒ No ❒ Yes; specify type(s) and reaction(s):_____

_____

Is this child taking any type of medication at this time? ❒ No ❒ Yes; please list below :

Name of Medication	Dosage	Duration	Reason

Has this child experienced any serious traumatic events? ❒ No ❒ Yes. If so, please explain:_____

_____

Has this child ever been physically abused? ❒ No ❒ Yes. If so, please explain:_____

_____

Has this child ever been sexually abused? ❒ No ❒ Yes. If so, please explain:_____

_____

Is this child *currently* involved in any type of professional mental health treatment? ❒ No ❒ Yes

Has this child ever been involved in any type of professional mental health treatment? ❒ No ❒ Yes

Name of therapist Age of this child at the time of treatment Duration Purpose of therapy

Has this child ever been taken to the Emergency Room? ❒ No ❒ Yes; at age_____Reason _____

Has this child undergone any type of surgery? ❒ No ❒ Yes; at age_____Type of Surgery_____

Was this child hospitalized for any other type of illness thus far not covered? ❒ No ❒ Yes; at age _____Reason_____

Has this child suffered any type of head injuries? ❒ No ❒ Yes; at age _____With loss of consciousness?_____

Has this child experienced any seizures? ❒ No ❒ Yes; at age_____Cause of seizures_____

Has this child suffered from ear infections? ❒ No ❒ Yes; specify the types of medical treatment this child has received for his/her infections (e.g., antibiotics, antihistamines, tubes).____

Total number of ear infections (approximately)_____ Longest duration of any ear infection_____

Do you see this child as:

hyperactive	❒ No	❒ Yes	acting without thinking	❒ No	❒ Yes
having problems with attention and concentration?	❒ No	❒ Yes	engaging in reckless behavior	❒ No	❒ Yes
forgetful	❒ No	❒ Yes	disorganized	❒ No	❒ Yes
frequently losing things	❒ No	❒ Yes			

Is this child, or was this child, associated with a spiritual/religious community, group or place of worship?_____

What is the name of the organization?_____

CHILD'S EDUCATIONAL PLACEMENT

Name of School School District Grade

Type of Classroom Placement (e.g., regular, ED, LD, Resource Room, etc.)

Generally, what are this child's grades? ❒ A/B ❒ B/C ❒ C/D ❒ D/F

Did this child repeat any grades? ❒ No ❒ Yes; grade(s)_____

Did this child fail any subjects? ❒ No ❒ Yes; which subject(s)_____

Does this child currently receive any special education services? ❒ No ❒ Yes; type_____
(e.g., self-contained class, resource room, reading lab)
Hours/day or week_____

MOTHER'S FAMILY HISTORY

Name:_____Birth Date:_____Age:_____

Birth Place:_____Religion/Church:_____

Highest Grade Completed:_____Highest Degree:_____

Have you experienced difficulties with learning? ❒ No ❒ Yes; please describe_____

Any mental health problems for which you have received treatment? ❒ No ❒ Yes; please describe the problem and the treatment received._____

Any medical problems? ❒ No ❒ Yes If yes, please specify._____

Do you smoke cigarettes? ❒ No ❒ Yes; cigarettes/day_____

Do you currently drink alcohol? ❒ No ❒ Yes; type of alcohol_____

Number of drinks/day/week/month_____

Do you currently use any type of drugs? ❒ No ❒ Yes; type of drugs_____

Frequency_____

Occupation_____ Current Place of Employment_____

During which years of your child's life have you worked?_____

Current marital status:

Married	_____years	Separated	_____years
Partner	_____years	Divorced	_____years
Single	_____years	Widowed	_____years

Other (please explain):_____

Marital History: How many times been married (including current)?_____

FATHER'S FAMILY HISTORY

Name:_____ Birth Date:_____ Age:_____

Birth Place:_____ Religion/Church:_____

Highest Grade Completed:_____ Highest Degree:_____

Have you experienced difficulties with learning? ❒ No ❒ Yes; please describe_____

_____

Any mental health problems for which you have received treatment? ❒ No ❒ Yes; please describe the problem and the treatment received._____

Any medical problems? ❒ No ❒ Yes; please specify._____

Do you smoke cigarettes? ❒ No ❒ Yes; cigarettes/day_____

Do you currently drink alcohol? ❒ No ❒ Yes; type of alcohol_____

Number of drinks/day/week/month_____

Do you currently use any type of drugs? ❒ No ❒ Yes; type of drugs_____

Frequency_____

Occupation_____ Current Place of Employment_____

During which years of your child's life have you worked?_____

Current marital status:

Married	_____years	Separated	_____years
Partner	_____years	Divorced	_____years
Single	_____years	Widowed	_____years

Other (please explain):_____

Marital History: How many times been married (including current)?_____

CHILD/FAMILY MEDICAL HISTORY

Has **your child** or anyone in his/her **family of origin** ever had the following? (For family, list the child's relationship to the person)

	Child?	**Family?**	**Relationship**
ADHD	☐ Yes ☐ No	☐ Yes ☐ No	_____
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	_____
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	_____
Type?	_____	_____	
Cardiac Disease	☐ Yes ☐ No	☐ Yes ☐ No	_____
Chronic Lung Disease	☐ Yes ☐ No	☐ Yes ☐ No	_____
Cystic Fibrosis	☐ Yes ☐ No	☐ Yes ☐ No	_____
Dementia/Alzheimer's	☐ Yes ☐ No	☐ Yes ☐ No	_____
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	_____
Fibromyalgia	☐ Yes ☐ No	☐ Yes ☐ No	_____

High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	_____
High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	_____
Irritable Bowel	☐ Yes ☐ No	☐ Yes ☐ No	_____
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No	_____
Migraine Headaches	☐ Yes ☐ No	☐ Yes ☐ No	_____
Peptic Ulcer	☐ Yes ☐ No	☐ Yes ☐ No	_____
Rheumatoid Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	_____
Stroke	☐ Yes ☐ No	☐ Yes ☐ No	_____
Thyroid Disease	☐ Yes ☐ No	☐ Yes ☐ No	_____
Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No	_____
Addictions	☐ Yes ☐ No	☐ Yes ☐ No	_____
Type?	_____	_____	
Type?	_____	_____	
Anxiety	☐ Yes ☐ No	☐ Yes ☐ No	_____
Bipolar	☐ Yes ☐ No	☐ Yes ☐ No	_____
Depression	☐ Yes ☐ No	☐ Yes ☐ No	_____
OCD	☐ Yes ☐ No	☐ Yes ☐ No	_____
Phobias	☐ Yes ☐ No	☐ Yes ☐ No	_____
Schizophrenia	☐ Yes ☐ No	☐ Yes ☐ No	_____
Suicide Attempts	☐ Yes ☐ No	☐ Yes ☐ No	_____
Suicide (Completed)		☐ Yes ☐ No	_____

Other significant personal or family health issues:_____

OTHERS IN THE HOME

Name	Age	Birth Date	Relationship to Patient

SIBLINGS WHO HAVE MOVED OUT OF THE HOME

Name	Age	Birth Date	Relationship to Patient

Please use this space for any additional information/comments you wish to share with us about your child or family._____

SAMARITAN COUNSELING CENTER

1803 OREGON PIKE • LANCASTER, PA 17601 • 717-560-9969 • FAX 717-560-9553

COUNSELING POLICY

Thank you for entrusting Samaritan Counseling Center with your care. All new clients are seen initially as a consultation for the purpose of evaluating the nature of personal needs and difficulties, discovering the desirability of counseling or referral, and recommending the type(s) of counseling.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. You have the right to discontinue therapy at any time by notifying your therapist of your decision.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding treatment. It is our practice to strive to come to an agreement, although there may be times we may not be able to in the best interests of your child's therapeutic progress. In addition, our role as your child's therapist is limited to only providing treatment, and we are ethically bound to refrain from making recommendations concerning custody or visitation arrangements.

It is our belief that we can best assist you if your treatment is coordinated with other health care professionals who are treating you. In order to accomplish this, with your permission, we will initiate contact with your primary care provider or other pertinent providers.

Samaritan Counseling Center is a faith-aware 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 within the belief system of the client. The Center's therapists do not impose their personal beliefs upon clients and only include discussion of spirituality/religion/faith according to the expressed preference of the client.

APPOINTMENTS AND CANCELLATIONS: **If you are unable to keep a scheduled appointment, SCC must be notified at least 24 hours in advance. This can be accommodated by talking with the receptionist or your therapist or leaving a message on SCC's voice mail system. For cancellations or reschedules made with less than 24 hours notice or for a missed appointment, clients will be charged $40.** If two or more appointments are missed, cancelled or rescheduled with less than 24 hours notice, clients will be charged $80 for each missed or late cancelled appointment. Unforeseen emergency situations will be taken into account. If you have any questions, please discuss this policy with your therapist.

CONFIDENTIALITY: Legally and ethically, the relationship between therapist and client is of a confidential nature. This means that any and all information which is given to the therapist during any session cannot be divulged by the therapist without the client's written consent. However, there are several instances in which confidentiality must be breached due to legal and ethical requirements of the therapist, such as 1) a clear and imminent danger of physical harm to the client or others, 2) therapist suspicion that any child (i.e., under the age of 18) has been abused (including the viewing of child pornography), and 3) a court order issued by a judge. Please review any questions about these limits to confidentiality with your therapist.

There may be times where a spouse, family member, or friend, participates in therapy to assist in your treatment. These persons would not be considered a patient, and therefore would not need to consent to treatment, would not be given a diagnosis or treatment plan, nor would they have any right to access your chart without your written consent.

Please remember that in order to bill your insurance company for your services, information must be provided to your insurer. In most cases, this information is the diagnosis code for your treatment here but an insurer, as the payor, may request additional information, such as a treatment plan or progress notes. We release the minimum amount of information required for compliance. In situations such as worker's compensation or an auto accident claim, your record from each session must accompany each claim for each date of service. Like Samaritan Counseling Center, your insurer must comply with privacy practices as a part of the Health Insurance Portability and Accountability Act (HIPAA).

EMERGENCIES: The Center does not provide emergency services. If a client has an **urgent** concern, that client's therapist will try to schedule an appointment with the client as soon as possible. The Crisis Intervention Center (394-2631) or your local emergency room are available for emergencies.

TERMINATION: If a client makes the decision to terminate counseling, SCC requests that a termination session be scheduled with the client's therapist. This is to allow time to finish the therapeutic process and to provide adequate aftercare.

CONSULTATION, EDUCATION, AND SUPERVISION: Relevant material from the counseling sessions may be discussed with professional staff and consultants for consultation, education, or supervision purposes. All information will be handled professionally and confidentially.

CONCERNS: Client satisfaction and quality of care are of utmost importance at Samaritan Counseling Center. Clients who have a complaint or would like to express concerns are encouraged to discuss the issue directly with their therapist. Clients may also contact the Executive Director, Steven Schedler, at 717-560-9969, ext. 252, or the Chair of the Board of Directors in care of Samaritan Counseling Center, 1803 Oregon Pike, Lancaster, PA 17601 in an envelope marked "Confidential". The Executive Director or Chair of the Board of Directors will respond to your complaint, in writing, within two weeks of receiving your complaint. The SCC will not retaliate against any person for filing a complaint.

Samaritan Counseling Center locations are smoke-free and weapons-free (knives, firearms, etc.) environments.

In the event we must contact you by telephone to change your appointment or request information, may we contact you and leave a message:

By cell? Yes ☐ No ☐
At home? Yes ☐ No ☐
At work? Yes ☐ No ☐

Other (List location and phone):_____

Your participation here is confidential. However, in the event of an emergency, we ask that you provide us with an emergency contact. **No other information will be released other than the emergency issue and status without a signed consent. By providing us with the information below, you agree that we may contact this person in the event of an emergency.**

Emergency Name	Phone number(s)	Relationship

IN THE INTEREST OF OUR WORKING TOGETHER, I AGREE TO ABIDE BY THE POLICIES ON THIS STATEMENT AND SIGNIFY THAT I HAVE RECEIVED AND UNDERSTAND THE INFORMATION CONTAINED HEREIN.

Client signature (or parent/guardian signature if client is a minor) Date

***Signature of minor client, if minor is 14 years or older** Date

Staff signature Date

Office Use Only
☐ ID Verification
File Copy? Yes___No___

SAMARITAN COUNSELING CENTER

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FEE POLICY

COUNSELING FEES AND PAYMENT: **All fees for services received at the Samaritan Counseling Center (SCC) are your responsibility**. Since insurance coverage is variable, SCC cannot guarantee what services will be covered by any insurance plan. SCC requests that you contact your insurance company for benefit information related to outpatient mental health.

If SCC **is a contracted** provider with your insurance company, a co-pay and/or co-insurance will be expected at the time of each session. Co-pays/co-insurance/deductibles are determined by your insurance company and your plan. If your payment is determined to be incorrect upon receipt of the Explanation of Benefits from the insurance company, you are responsible for any underpayment; SCC will refund any overpayments. Clients are also responsible for any annual deductible. **Please obtain co-pay, co-insurance, deductible and mental health benefits information from your insurance company prior to the first appointment.**

If SCC **is not a contracted** provider with your insurance company, payment in full will be expected at the time of each session. An itemized receipt will be given to you at each session for submission to your insurance company. Please refer to the fee schedule below.

We accept Mastercard/Visa/Discover, check made payable to Samaritan Counseling Center or cash. A $15 service charge will be levied on all checks returned by a bank for insufficient funds.

If you or the client (if the client is a child) are not the responsible party for payment, please print the name and address of the person responsible. If the payor is not you, please have the responsible party read and sign a copy of this form as well.

Name:_____

Address/City/State/Zip:_____

FEE SUBSIDIES : **In the case of special financial need**, a subsidized fee (based in part on total family income and size) may be arranged with the therapist as funds are available. Payment of the client's portion of the fee is to be made at each session.

APPOINTMENTS AND CANCELLATIONS: **If you are unable to keep a scheduled appointment, SCC must be notified at least 24 hours in advance. This can be accommodated by talking with the receptionist or your therapist or leaving a message on SCC's voice mail system. For cancellations or reschedules made with less than 24 hours notice or for a missed appointment, clients will be charged $40.** If two or more appointments are missed, cancelled or rescheduled with less than 24 hours notice, clients will be charged $80 for each missed or late cancelled appointment. Unforeseen emergency situations will be taken into account. If you have any questions, please discuss this policy with your therapist.

ANCILLARY SERVICES: If you request services beyond the typical standard of care, such as records review from another provider or a school, phone or in-person discussion with, but not limited to, such contacts as a school counselor, another provider or a case manager, these services are billed directly to you at $100 per hour and are not reimbursable by your insurance company.

SERVICE	REGULAR FEE	FEE IF PAID AT TIME OF SERVICE	SERVICE	REGULAR FEE	FEE IF PAID AT TIME OF SERVICE
Adult Initial Evaluation	$160.00	$145.00	Child or Family Ongoing Session (38-52 minutes minutes)	$120.00	$105.00
Child or Family Initial Evaluation	$170.00	$155.00	Abbreviated session (greater than 16 minutes)	$80.00	$72.00
Adult Ongoing Session (38-52 minutes minutes)	$110.00	$95.00	Extended session (greater than 53 minutes)	$140.00	$125.00
Ancillary Services: $100 per hour. Not billable to insurance (see above).					

Vouchers from Partner Churches are worth one session – session can be one initial evaluation or one ongoing session.

_____

Client signature (or parent/guardian signature if client is a minor) Date

_____

***Signature of minor client, if minor is 14 years or older** Date

_____

Staff Signature Date

Samaritan Counseling Center

1803 Oregon Pike
Lancaster, PA 17601
717-560-9969

Notice of Privacy Practices

Steven Schedler, Executive Director
sschedler@scclanc.org

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a copy of this privacy notice
- Get a list of those with whom we've shared your information
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Provide mental health care
- Discuss appointments, treatment or goals with those you choose

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting of impaired drivers

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We will never share any substance abuse or HIV disclosures or treatment records without your written permission.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

SAMARITAN COUNSELING CENTER

1803 OREGON PIKE • LANCASTER, PA 17601 • 717-560-9969 • FAX 717-560-9553

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review the **Notice of Privacy Practices** of the Samaritan Counseling Center. I understand that the terms of this Notice may change from time to time, in which case I will be notified of such changes, either verbally or in writing, and, upon my request will be provided the opportunity to review the new Notice.

I understand that I have the right to request that the Samaritan Counseling Center restrict the use or disclosure of protected health information for carrying out treatment, payment and/or health care operations. I also understand that the Samaritan Counseling Center is not required to agree to any restriction; however, if the requested restrictions are agreed to by the Samaritan Counseling Center, those restrictions are binding.

In addition, I understand that the Samaritan Counseling Center may make treatment conditional on my signing this Consent.

Finally, I understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that the Samaritan Counseling Center has acted in reliance hereon.

By my signature below, I give my consent to the Samaritan Counseling Center to use and disclose, for the purpose of carrying out treatment, payment, and/or health care operations, protected health information in reference to:

Client Name	Date of Birth	Relationship of Person Completing this Form to Client Listed (Self, Parent, Guardian, etc.)

Client signature (or parent/guardian signature if client is a minor) Date

***Signature of minor client, if minor is 14 years or older** Date

Staff Signature Date

My signature above verifies that the Client received adequate explanation to make an informed decision

Restrictions: _____

Comments: _____ _____

Client Initials

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			

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CONSENT FOR USE OF EMAIL AND TEXT COMMUNICATIONS

I am consenting to email and text communications between myself and the Samaritan Counseling Center, with the following understanding:

Potential Risks:

- Information transmitted may not be sufficient for a clear understanding between parties.
- Unencrypted email or text communication is **not** a HIPAA compliant form of communication. The Samaritan Counseling Center does not have encryption capabilities to maintain the procedures and protocols necessary for secure communication via email or text. There may be issues beyond the control of the Samaritan Counseling Center that could cause a breach of privacy of your confidential information. With your signature, you are affirming that you understand and are agreeing that the Center cannot guarantee any safety of the information that is discussed with you over these types of communication.
- Under no circumstances can the Samaritan Counseling Center guarantee that any email or text communication will be confidential.

I understand that the following alternatives are available to me:

- A face-to-face appointment with the clinician.
- Communication via telephone.

I understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that the Samaritan Counseling Center has acted in reliance hereon.

By my signature below, I understand that any communication via email or texting is not secure and that the Samaritan Counseling Center does not guarantee the privacy of any communication via these types of communication.

_____
Client Name

_____ _____ _____
Date of Birth of Client | Your relationship to Client (Self, Parent, Guardian, etc.). | If not Client, Print your Name

_____
Email Address

_____ _____
Client signature (or parent/guardian signature if client is a minor) | Date

_____ _____
***Signature of minor client, if minor is 14 years or older** | Date

_____
Email Address for minor 14 years or older (if different than email address above)

_____ _____
Therapist Signature* | Date

*My signature above verifies that the client received adequate explanation to make an informed decision.

Restrictions: _____

Verbal Authorization
The undersigned verify verbal authorization has been given. Please request client review form online for their informed consent.

_____ _____ _____ _____
Witness Signature | Date | Witness Signature | Date

Samaritan Counseling Center

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CONSENT TO VIDEOTHERAPY SERVICES

Client Name:_____

Date of Birth:_____ Phone Number:_____

Address:_____

City, State, Zip:_____

For avoidance of any doubt, the terms Samaritan Counseling Center, "**we**", "**us**", or "**our**" refer to Samaritan Counseling Center and the terms "you" and "yours" refer to the client identified above.

Introduction

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 client 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, photo images, personal health information or other data between a member and a Provider;
- Interactions between a client 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 in the provision of 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, your Provider's treatment options may be limited.

Additional Information

- You must have a webcam or a smartphone to utilize Videotherapy services.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be in a quiet, private space that is free from distractions.
- It is important to be on time. If you need to cancel or change your Videotherapy session, you must notify the Provider at least 24 hours in advance. Late cancel/missed appointment charges may apply.
- In the event of technical problems, the Provider will contact you via phone number on file.
- Please provide the contact information for at least one emergency contact.

By accepting this Consent to Videotherapy Services, 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 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.
8. 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.

Client Consent To The Use of Videotherapy Services

I have read this special Consent to Videotherapy Services 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 the Provider to use Videotherapy Services in the course of my diagnosis and treatment.

Client Name

Date of Birth of Client | Your relationship to Client (Self, Parent, Guardian, etc.). | If not Client, Print your Name

Email Address

Client signature (or parent/guardian signature if client is a minor) | Date

***Signature of minor client, if minor is 14 years or older** | Date

Email Address for minor 14 years or older (if different than email address above)

Therapist Signature* | Date

*My signature above verifies that the client received adequate explanation to make an informed decision.

Restrictions:

Verbal Authorization

The undersigned verify verbal authorization has been given. Please request client review form online for their informed consent.

Witness Signature Date | Witness Signature Date

Samaritan Counseling Center

1803 Oregon Pike ● Lancaster, PA 17601 ● 717-560-9969

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION FROM/TO PRIMARY CARE PHYSICIAN

Please read and complete all items

Client Name:_____

Address:_____ City, State, Zip:_____

Date of Birth:_____ Phone Number:_____

☐ I authorize the use/disclosure of health information about me as described below:
OBTAIN from or **RELEASE** to what organization:

Organization Name:_____ Phone:_____

Contact Name:_____ Fax:_____

Address:_____

City, State, Zip:_____

Complete this section with your Clinician at the time of your appointment.
This authorization is for the purpose of Coordination of Care with Primary Care Physician.

- □ Initiation of Treatment Letter
- □ Summary of Treatment to Date
- □ Termination of Treatment Letter
- □ Discharge Summary
- □ Treatment Plan
- □ Verbal and Phone Communication
- □ Psychological Evaluation
- □ Medications
- □ Medical History
- □ Lab Reports
- □ Other_____

☐ I do NOT wish Samaritan Counseling Center to disclose my Health Information to my Primary Care Physician at this time.

I understand that the information in my health record will include information about behavioral or mental health services. It may also include information about treatment of alcohol or drug abuse or information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained:

Alcohol, Drug or Substance Abuse Records	□ Yes	□ No
HIV Testing and Results	□ Yes	□ No

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.

I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires on_____ or one year after the date of execution, whichever comes first.

_____

Client signature (or parent/guardian signature if client is a minor or unable to consent) Date

If Parent/Guardian, Print Name:_____

_____

***Signature of minor client, if minor is 14 years or older** Date

If the patient is unable to consent or is a minor, complete the following. Patient is:
□ Minor □ Incompetent □ Disabled
Legal Authority:
□ Custodial Parent □ Legal Guardian □ Power of Attorney for Healthcare □ Authorized Legal Representative

If you have any questions, please call 717-560-9969.

INFORMED CONSENT FOR IN-PERSON SERVICES
DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about the decision of both you, as the client, and your therapist at the Samaritan Counseling Center to resume in-person services in light of the public health crisis. Please read this carefully and let your therapist know if you have any questions.

Decision to Meet Face to Face
My therapist at the Samaritan Counseling Center (SCC) and I, the client or the parent/guardian of the client, have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, your therapist may require that you again meet via Videotherapy. If you have concerns about going back to Videotherapy, please discuss this with your therapist in order to try to address the issue. Please be aware that your therapist may determine that a return to Videotherapy is necessary for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, Videotherapy services, your therapist will respect that decision, as long as it is clinically appropriate. Reimbursement for Videotherapy services, however, is determined by the insurance companies and applicable law, so please be sure to check with your insurance company that Videotherapy services are covered.

Risks of Opting for In-Person Services
Please understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, your family members, SCC staff and their family members, and other clients) safer from exposure, sickness and possible death. Your failure or refusal to adhere to these safeguards may result in starting/returning to a Videotherapy arrangement. Initial each to indicate that you understand and agree to these actions:

_____ You will only keep your in-person appointment if you are symptom free.

_____ If you have been exposed to someone with COVID-19, or traveled outside the country or to a state identified for quarantine within the last 14 days, please contact the Center to change your appointment to a virtual session.

_____ If you have tested positive for COVID-19, you may only be seen for an in-person session when you have been symptom and fever free for at least 72 hours.

_____ You will wash your hands or use hand sanitizer when you enter the building.

_____ You will adhere to the safe distancing precautions in your therapist's office or anywhere else in the building.

_____ You will wear a mask in all general areas of the office, including the waiting room and hallways.

_____ If you are requested to wear a mask, you agree to do so.

_____ You will maintain a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with SCC staff.

_____ If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. (Please, only bring a child if that child is the client.)

_____ If a resident of your home tests positive for the infection, you will immediately let SCC staff know and your therapist will then begin or resume treatment via Videotherapy.

_____ You are/are not (circle one) fully vaccinated for the COVID-19 virus.

SCC staff may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, your therapist will discuss any necessary changes.

SCC's Commitment to Minimize Exposure
Samaritan Counseling Center has taken steps to reduce the risk of spreading the virus within the office. Please let us know if you have questions about these efforts.

In the Event of Illness
You understand that SCC is committed to keeping you, SCC staff and all of our families safe from the spread of this virus. If you show up for an appointment and your therapist or other SCC staff believe that you have a fever or other symptoms, or believe you have been exposed, SCC will require you to leave the office immediately. Your therapist can follow up with services by Videotherapy as appropriate.

If a member of the SCC staff with whom you have had contact tests positive for the coronavirus, SCC will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you later test positive for the coronavirus, or if you have been exposed to someone at our office who then tests positive, SCC staff may be required to notify local health authorities that you have been in the office. If SCC has to report this, we will only provide the minimum information necessary for their data collection and will not go into any details of the reason(s) for your visit(s). By signing this form, you are agreeing that Samaritan Counseling Center may do so without an additional signed release.

Informed Consent
This agreement supplements to the *Acknowledgement of Receipt of Notice of Privacy Practices*, the *Counseling Policy* and the *Fee Policy* that you signed at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

Client signature (or parent/guardian if client is a minor)	Date
Signature of minor client, if minor is 14 years or older	Date
Therapist	Date

Our/My Safety Precautions in Effect during Pandemic

Our office is taking the following precautions to protect our clients and help slow the spread of the coronavirus.

- Seating throughout the building has been arranged to allow for appropriate physical distancing.
- Restroom soap dispensers are maintained and everyone is required to sanitize or wash their hands upon entry to the building.
- Hand sanitizers that contain at least 60% alcohol are available at each entrance, at the reception counter, and in every office and meeting room.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed.
- Common areas are thoroughly disinfected each day.