(717) 560-9969
Fax (717) 560-9553

SAMARITAN COUNSELING CENTER
Healthy Minds. Strong Communities.

1803 Oregon Pike
Lancaster, PA 17601
www.scclanc.org

Parent Agreement

Adolescents Ages 14-17

Client Name:_____ Date of Birth:_____ Today's Date:_____

Your Name:_____

This form is called a Parent Agreement. Your child's health professional ("therapist") at Samaritan Counseling Center ("SCC" or the "Center") has asked you to read and sign this Consent before your child starts therapy. Please review the information. If you have any questions, please contact us at 717-560-9969.

Prior to beginning treatment, it is important for you to understand the Samaritan Counseling Center's approach to child therapy, especially when parents/guardians are involved in custody disputes. These situations often present risks to your child's confidentiality and progress during the course of his/her treatment.

One risk of child therapy involves disagreement among parents/guardians and/or disagreement between parents/guardians and therapist regarding the best interests of your child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in securing and maintaining that trust. It is the policy of the Samaritan Counseling Center to provide you with general information about treatment status. I will not share with you what your child has disclosed to me without your child's consent, with the exceptions of there being any danger to your child or another person.

BY SIGNING THIS CONSENT YOU AGREE that no party will ask me to release records to any party, nor to testify in court, whether in person, or by affidavit. I will also not share information based on any attempts by any party to gain advantage in any legal proceeding. In particular, you agree that in any such proceedings, no party will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent/guardian's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $150 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

FEES AND PAYMENT FOR SERVICES: All fees for services received at the Samaritan Counseling Center 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 and/or deductible amount 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 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:

SERVICE	**FEE**
Adult Initial Evaluation	$160.00
Child or Family Initial Evaluation	$170.00
Adult Ongoing Session (38-52 minutes)	$110.00
Child or Family Ongoing Session (38-52 minutes)	$120.00
Abbreviated session (greater than 16 minutes)	$80.00
Extended session (greater than 53 minutes)	$140.00

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 – or have a service value of $100. No refunds are made for unused portions of vouchers.

We accept Mastercard/Visa/Discover/AmericanExpress, 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.

Samaritan Counseling Center requests that you keep a valid credit or debit card on file through this patient portal (see the Payment Authorization Form). This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with the practice ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

NO-SHOW AND LATE CANCELLATION FEES: If your child is unable to attend therapy, you must contact Samaritan Counseling Center or your child's therapist at least 24 hours before your session. This can be accommodated by speaking with someone or leaving a voice mail. Otherwise, you may subject to fees. 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. Insurance does not cover these fees. Unforeseen emergency situations will be taken into account.

BALANCE ACCRUAL: Full payment is due at the time of your child's session. If you are unable to pay at that session, discuss this with your child's therapist. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service.

FEE SUBSIDIES: Thanks to Samaritan Counseling Center's generous donors, in the case of special financial need, a subsidized fee 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.

ADMINISTRATIVE FEES: Your child's therapist may charge administrative fees for requested services beyond the typical standard of care such as (but not limited to) records review from another provider or school, writing a letter or report at your request; or consulting with another healthcare provider or other professional outside of normal case management practices. These services are billed directly to you at $100 per hour and are not reimbursable by your insurance company. Payment is due in advance.

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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 (717-394-2631) or your local emergency room are available for emergencies.

TERMINATION: If a client makes the decision to terminate counseling, Samaritan Counseling Center requests that a termination session be scheduled with your 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.

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

ACKNOWLEDGEMENT: My signature on this document represents that I have received the Parent Agreement form and that I understand and agree to the information therein. Further, I consent to use an electronic signature to acknowledge this agreement.

Signature:_____Today's Date:_____

Printed Name:_____

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Client Contacts Form

Client Name:_____ Date of Birth:_____ Today's Date:_____

Contact Name: _____

Company Name:_____

☐ Emergency Contact ☐ Guardian ☐ Primary Care Physician

Relationship:_____ Date of Birth (if known):_____

Contact Address Line 1:_____

Contact Address Line 2:_____

Contact City/State/Zip:_____

Mobile Phone:_____ Home Phone:_____ Work Phone:_____

Fax:_____ Email Address: _____

Contact Name: _____

Company Name:_____

☐ Emergency Contact ☐ Guardian ☐ Primary Care Physician

Relationship:_____ Date of Birth (if known):_____

Contact Address Line 1:_____

Contact Address Line 2:_____

Contact City/State/Zip:_____

Mobile Phone:_____ Home Phone:_____ Work Phone:_____

Fax:_____ Email Address: _____

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Payment Authorization Form

Client Name:_____Date of Birth:_____Today's Date:_____

Payment Method Details

Payment Method: New Credit/Debit Card

Name on Card:_____

Card Number: _____

Card Expiration Date:_____Security Code:_____

Billing Address Line 1:_____

Billing Address Line 2:_____

Billing City/State/Zip:_____

Acknowledgement

The Samaritan Counseling Center may utilize my payment method(s) on file for any balances, including late cancellation and no-show fees, without additional authorizations.

Signature:_____

Printed Name:_____