



# Coastal Samaritan Counseling Center

*Instilling hope and healing*

1297 Professional Drive, Suite 101, Myrtle Beach, S.C. 29577

Telephone: (843) 448-4820 / Fax: (843) 448-9875

E-mail: [cscinfo@coastalsamaritan.org](mailto:cscinfo@coastalsamaritan.org)

## Client Intake Information Form

The information requested in this form will be kept confidential, and will help your counselor assist you.

Please fill out the form as completely as you can.

### GENERAL INFORMATION

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_ ☐ Male  
☐ Female

Street Address \_\_\_\_\_ City \_\_\_\_\_

☐ Cell

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ ☐ Home E-mail \_\_\_\_\_

May we leave a message on your phone? ☐ Yes ☐ No May we contact you by e-mail? ☐ Yes ☐ No

May we contact you by text message? ☐ Yes ☐ No

Referred By \_\_\_\_\_

Reason for Referral \_\_\_\_\_

Religious preference/

Reason for

Congregation Name \_\_\_\_\_

choosing CSCC \_\_\_\_\_

#### RACIAL/ETHNIC IDENTITY

☐ African-American ☐ Asian-American ☐ Hispanic  
☐ Native-American ☐ White/Caucasian ☐ Other

EMPLOYMENT ☐ Full-Time ☐ Part-Time

☐ Unemployed ☐ Stay At Home

#### EDUCATION Highest Level of Education Completed

☐ High School ☐ Graduate Degree ☐ Other  
☐ College Degree ☐ Professional Training

Place of employment \_\_\_\_\_

Type of work/position \_\_\_\_\_

PAYMENT METHOD Do you plan to file insurance ☐ Yes ☐ No Employee Assistance Program ☐ Yes ☐ No

Do you wish to apply for fee assistance ☐ Yes ☐ No

Name of person responsible for payment \_\_\_\_\_

FAMILY INFORMATION ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Cohabiting

# prior marriages?  Mother: age  ☐ Deceased Father: age  ☐ Deceased

CHILDREN				SIBLINGS			
First Name	Age	First Name	Age	First Name	Age	First Name	Age

## PROBLEM DEFINITION

Reason for seeking help now?

Are any of the following conditions a problem for you at this time? (check all that apply)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Anger             | <input type="checkbox"/> Substance Abuse   | <input type="checkbox"/> Relationship to Parents  |
| <input type="checkbox"/> Grief            | <input type="checkbox"/> Marriage Problems | <input type="checkbox"/> Chronic Fear      | <input type="checkbox"/> Relationship to Children |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Sexual Problems   | <input type="checkbox"/> Guilt Feelings    | <input type="checkbox"/> Loss of Meaning in Life  |
| <input type="checkbox"/> Irrational Fears | <input type="checkbox"/> Loss of Work/Job  | <input type="checkbox"/> Suicidal Feelings | <input type="checkbox"/> Loss of Faith in God     |
| <input type="checkbox"/> Nervousness      | <input type="checkbox"/> Self Esteem       | <input type="checkbox"/> Loss of Hope      | <input type="checkbox"/> Conflict at Work         |
| <input type="checkbox"/> Loneliness       | <input type="checkbox"/> Stress            | <input type="checkbox"/> Rage              | <input type="checkbox"/> Religious Doubts         |

☐ Other (List)

What would you like to see happen as a result of psychotherapy or counseling?

## MEDICAL/PSYCHOLOGICAL HISTORY

General Practitioner/Medical Doctor

Date of Last Medical Examination?

Last Name

First Name

Address

Any major surgeries, physical illnesses or mental illnesses in the last five years? ☐ Yes ☐ No If Yes, please list

Are you suffering any physical illnesses or symptoms at this time? ☐ Yes ☐ No If Yes, please list

## LIST CURRENT MEDICATIONS

Medication Name	MG	Per Day	Medication Name	MG	Per Day

Have you received help for drug or alcohol dependency?

☐ Yes ☐ No

Have you received psychotherapy or counseling in the past?

☐ Yes ☐ No

Do you have thoughts of harming yourself or others?

☐ Yes ☐ No

Are thoughts of harming yourself or others a frequent occurrence?

☐ Yes ☐ No

Do you dwell on these thoughts and wonder if you can control them?

☐ Yes ☐ No

Have you sought professional help because of these thoughts and feelings?

☐ Yes ☐ No

Emergency Contact

Contact Phone #

ACKNOWLEDGEMENT: Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

Signature

Date



# Coastal Samaritan Counseling Center

*Instilling hope and healing*

1297 Professional Drive, Suite 101, Myrtle Beach, SC 29577

Phone: (843) 448-4820/Fax: (843) 448-9875

E-mail: [cscinfo@coastalsamaritan.org](mailto:cscinfo@coastalsamaritan.org)

Website: [www.coastalsamaritan.org](http://www.coastalsamaritan.org)

## CONSENT AND AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name:

DOB:

Address:

SSN:

Provider's Name:

☐

I authorize the disclosure of my medical records from The Coastal Samaritan Counseling Center to the entity listed below.

☐

I authorize the disclosure of my medical records from the entity listed below to The Coastal Samaritan Counseling Center.

☐

I authorize the disclosure of my medical records from The Coastal Samaritan Counseling Center to myself, the client. (Same as Client Name Listed Above)

☐

I revoke my authorization to disclose my medical records from The Coastal Samaritan Counseling Center.

### RELEASE CONFIDENTIAL INFORMATION TO:

Name:

Address:

Phone:

Fax:

E-mail:

Relation to Client:

### PORION OF MEDICAL RECORD TO BE RELEASED:

☐ Entire Medical Record   ☐ Progress Notes   ☐ Summary Letter with dates and diagnosis

☐ Discharge Summary   ☐ Summary Letter with dates

I understand that all client information is confidential and my record cannot be disclosed without my written consent unless otherwise provide for by law. I understand that CSCC will only release records that were created and maintained by our counselors and center. We will not release records received from other clinics or providers. I acknowledge that the information being release was fully explained to me and that this consent is given freely. I also understand that I may withdraw my consent at any time by written notification to Coastal Samaritan Counseling Center.

Client Signature/Authorized Person

Date:

Witness Signature

Date:



# Coastal Samaritan Counseling Center

## *Instilling hope and healing*

1297 Professional Drive, Suite 101, Myrtle Beach, S.C. 29577

Telephone: (843) 448-4820 / Fax: (843) 448-9875

E-mail: [cscinfo@coastalsamaritan.org](mailto:cscinfo@coastalsamaritan.org)

Website: [www.coastalsamaritan.org](http://www.coastalsamaritan.org)

## Video Therapy Services Disclosure

### **VIDEO THERAPY SERVICES:**

CSCC offers Video Therapy Services (VTS) to delivery health care services using electronic communications to connect with individuals using interactive video and audio communications. The laws that protect confidentiality of your personal information also apply to Video Therapy Services. We take privacy and security very seriously. As a result, the VTS platform used by CSCC complies with HIPAA requirements. CSCC utilizes secure, encrypted audio/video transmission platforms to deliver VTS.

I understand that I have the rights with respect to Video Therapy Services:

1. The laws that protect the confidentiality of my personal information also apply to VTS. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the VTS interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of online therapy in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from VTS, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.
4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a face-to-face intervention if available with my counselor or referred to mental health professional that can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to counseling through VTS as they have been explained to me, and in choosing to participate in VTS, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to “face-to-face” psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of online therapy in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that the VTS provided by Coastal Samaritan Counseling Center falls under the policies and procedures already in place which was provided as part of this intake process including, the therapy process, your rights as a client, confidentiality, fees and payment, appointments and cancellation, insurance and other third-party payment and ending therapy.
8. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

PATIENT CONSENT TO THE USE VIDEO THERAPY SERVICES: I have read and understand the information provided above regarding VTS, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of online therapy services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of online therapy services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

---

Print Client Name

---

Client Signature

---

Date



## Therapy Information and Disclosure Form

### **WELCOME:**

The Coastal Samaritan Counseling Center (CSCC) welcomes you as a potential client. We believe it is important for you to be informed about the nature of counseling or psychotherapy, the policies and procedures governing the help you will receive here, the fees charged for our services, and your rights as a client. You will be asked to sign the Client Intake Signature Form, signifying your general consent to therapy.

### **COUNSELING AND PSYCHOTHERAPY IN THIS CENTER:**

The words counseling and psychotherapy (referred to below as “therapy”) are often used interchangeably to indicate forms of psychological help that address various kinds of personal and family distress such as depression, anxiety, adjustment difficulties at work and with other people, and marital and family conflicts. The goals of therapy range from the relief of symptoms to significant life change based on acquiring a better understanding of one’s personal, interpersonal, and social circumstances.

CSCC’s methods of treatment are based on standard practices common to the training and experience of psychotherapists, marriage and family therapists, psychologists, social workers, and pastoral counselors. Practitioners in this Center work within the standards and ethical guidelines of state licensing laws, of professional associations, and of the Solihden Institute. [A statement of Professional and Clinical Standards is available on request.] CSCC therapists also respond to the spiritual and theological needs of clients who recognize that values, beliefs, and religious affiliations make a difference in the process of changing and growing, and who want these factors to be considered in their therapy.

### **VIDEO THERAPY SERVICES:**

CSCC offers Video Therapy Services (VTS) to delivery health care services using electronic communications to connect with individuals using interactive video and audio communications. The laws that protect confidentiality of your personal information also apply to Video Therapy Services. Please be aware that there are risk in using VTS, including, but limited to the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of personal information could be disrupted or distorted by technical failure, the transmission of personal information could be interrupted by unauthorized persons. We take privacy and security very seriously. As a result, the VTS platform used by CSCC complies with HIPAA requirements. CSCC utilizes secure, encrypted audio/video transmission platforms to deliver VTS. Please see “Confidentiality” below for more information. Informed consent to Video Therapy Services must be giving before engaging in VTS. Please ask for more information.

### **THERAPY PROCESS:**

Therapy begins with an *intake process* designed to evaluate your needs and difficulties and to help you and the therapist decide about engaging in therapy. This may take one interview or a series of interviews. If becoming a client here does not seem feasible, you will be helped to select a more appropriate place for the help you need. The *therapy process* itself may take many forms, depending on the issues that need to be addressed and how far you wish to go in dealing with them. Treatment is guided by a *treatment plan* that you and your therapist both agree to pursue. Therapy ends when the work is done, or at the point you decide to end it.

Clients are entitled to receive information from therapists about the credentials, education, methods of therapy, the possible duration of therapy, and fees. Your therapist will disclose these facts and opinions in the initial interviews.

### **THERAPY POLICIES AND PROCEDURES:**

**YOUR RIGHTS AS A CLIENT:** You have all the rights established by the state of South Carolina governing clinical practices. These include the rights of consent to treatment, of seeking disclosure from your therapist about his or her qualifications, or requesting a different therapist, or ending treatment at any time, or accessing the client

grievance procedures, and of having the records of your treatment kept in confidence (see confidentiality statement below).

**CONFIDENTIALITY:** What you tell your therapist will be kept strictly confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, as a part of the professional practice of this Center. By law, there are circumstances when the therapist must report information to the appropriate persons or agencies, for example: a) if you threaten grave bodily harm or death to yourself or someone else; b) if you reveal information about child, elder or other vulnerable adult abuse; and c) if ordered by a court of law. If your therapy is court ordered, the results of treatment or test must be revealed to the court. Also, in keeping with standard profession practice, your case records may be viewed by Samaritan Center staff, consultants, and accreditation reviewers for purposes of diagnosis, treatment, and quality control. In all other instances, your written permission is required before your therapist or the Center can reveal information about your treatment.

### **RELEASE OF CONFIDENTIAL RECORDS POLICY**

In compliance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, CSCC has developed policies and procedures to ensure that your confidential records are handled in a manner meeting necessary guidelines. Records will be release directly to third party entities (e.g. Lawyers, Doctors, etc.) only upon written request from the patient. Confidential records may take up to 10 days to be completed once all forms are received by CSCC. CSCC will only release records that were created and maintained by our counselors and center. We will not release records received from other clinics or providers. Except for authorizations to provide information to third-party payers, authorizations are valid for 1 year. Revocation must be in writing.

**FEES AND PAYMENT:** The Therapy Fee Agreement that you will complete in the intake interview will state your fee and payment requirements. We request payment at the time of your therapy appointment. You may pay by cash, check, or credit card. Each check returned because of insufficient funds will result in a charge to you of thirty dollars (\$30.00) plus any bank charges. If your account is more than sixty (60) days overdue, we reserve the right to turn your account over to a collection agency. You specifically waive any right to confidentiality regarding financial information given by the Samaritan Center to a collection agency.

**APPOINTMENTS AND CANCELLATIONS:** All appointments are made with your counselor unless the counselor specifically asks the office to make the appointment. In the event that you need to miss a scheduled appointment, please extend the professional courtesy of cancelling as early as possible, so that the hour reserved for you may be offered to someone else needing profession counseling services.

**Failure to give a reasonable twenty-four (24) hour notification for cancellations to the Center will result in a minimum charge of thirty-five dollars (\$35.00). I understand that a thirty-five dollar (\$35.00) fee will be charged for no- shows and it must be paid prior to scheduling the next appointment. Your credit card/debit card on file will be charged for the no-show/late cancellation fee.** For your convenience, the Center maintains a voice mail system that records messages 24 hour per day.

**INSURANCE AND OTHER THIRD-PARTY PAYMENTS:** If you have insurance or some other third-party coverage (e.g., a managed care organization or employee assistance program) that pays for therapy, you are responsible for giving the Center this information on the Insurance Information Form. The Center will file your claims if the information you give us is accurate and complete. The Center does not guarantee that your insurance or other coverage will pay your claim. You are responsible for the account balance and for deductibles and co-payments required by the insurance or third-party company.

**ENDING THERAPY:** Although you may end therapy at any time, it is preferred that you have a least one face-to-face concluding appointment with your therapist rather than terminating by telephone, mail, or by not showing up. In general, your file will be closed after three (3) months of no appointments, unless other arrangements have been made with your counselor or office administration. At the time of discharge, clients may be given or sent a Client Satisfaction Form that is used to elicit feedback on the therapy process. This is a valuable tool to increase the Centers' awareness of the strengths and weaknesses of our services.





# Coastal Samaritan Counseling Center

## *Instilling hope and healing*

1297 Professional Drive, Suite 101, Myrtle Beach, S.C. 29577

Telephone: (843) 448-4820 / Fax: (843) 448-9875

E-mail: [cscinfo@coastalsamaritan.org](mailto:cscinfo@coastalsamaritan.org)

Website: [www.coastalsamaritan.org](http://www.coastalsamaritan.org)

## HIPAA Notice of Privacy Practices

This notice tells you how **Coastal Samaritan Counseling Center** makes use of your health information, how this information might be disclosed to others, and how you may get access to the same information. You will be asked to sign the Client Intake Signature Form, signifying that you were offered a copy of our Notice of Privacy Practices.

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 South Carolina 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 **04-14-2003** 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 **Coastal Samaritan Counseling Center**. 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.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center's operations.  
Examples: 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 sent to, for any reason you want. You may revoke this authorization in writing any time 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 that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.

8. The Center's Confidentiality Agreement contains information applicable to special disclosures required by South Carolina law regarding special circumstances in which confidentiality may be or must be waived (i.e. abuse of a child). Please refer to the pink Confidentiality agreement that has been or will be given to you at the time of your first appointment.

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 **Coastal Samaritan Counseling Center, 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 \$ .50 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 which, 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:

Compliance Officer: **Clinical Director**  
Telephone: **843-448-4820**  
Fax: **843-448-9875**  
E-mail: [clinicaldirector@coastalsamaritan.org](mailto:clinicaldirector@coastalsamaritan.org)

Alternate Compliance Officer: **Office Administrator**  
Telephone: **843-448-4820**  
Fax: **843-448-9875**  
E-mail: [officeadmin@coastalsamaritan.org](mailto:officeadmin@coastalsamaritan.org)

Address: **Coastal Samaritan Counseling Center**  
**901 N. Kings Highway**  
**Myrtle Beach, SC 29577**

- M. You may also submit a written complaint to the Secretary of the United States Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, D. C. 20201

---

**Client Signature**

---

**Date**



# Coastal Samaritan Counseling Center

## *Instilling hope and healing*

1297 Professional Drive, Suite 101, Myrtle Beach, S.C. 29577

Telephone: (843) 448-4820 / Fax: (843) 448-9875

E-mail: [cscinfo@coastalsamaritan.org](mailto:cscinfo@coastalsamaritan.org)

Website: [www.coastalsamaritan.org](http://www.coastalsamaritan.org)

## HIPAA Notice of Privacy Practices

This notice tells you how **Coastal Samaritan Counseling Center** makes use of your health information, how this information might be disclosed to others, and how you may get access to the same information. You will be asked to sign the Client Intake Signature Form, signifying that you were offered a copy of our Notice of Privacy Practices.

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 South Carolina 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 **04-14-2003** 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 **Coastal Samaritan Counseling Center**. 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.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center's operations.  
Examples: 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 sent to, for any reason you want. You may revoke this authorization in writing any time 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 that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.

8. The Center's Confidentiality Agreement contains information applicable to special disclosures required by South Carolina law regarding special circumstances in which confidentiality may be or must be waived (i.e. abuse of a child). Please refer to the pink Confidentiality agreement that has been or will be given to you at the time of your first appointment.

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 **Coastal Samaritan Counseling Center, 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 \$ .50 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 which, 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:

Compliance Officer: **Clinical Director**  
Telephone: **843-448-4820**  
Fax: **843-448-9875**  
E-mail: **clinicaldirector@coastalsamaritan.org**

Alternate Compliance Officer: **Office Administrator**  
Telephone: **843-448-4820**  
Fax: **843-448-9875**  
E-mail: **officeadmin@coastalsamaritan.org**

Address: **Coastal Samaritan Counseling Center**  
**901 N. Kings Highway**  
**Myrtle Beach, SC 29577**

- M. You may also submit a written complaint to the Secretary of the United States Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, D. C. 20201



# Coastal Samaritan Counseling Center

## *Instilling hope and healing*

1297 Professional Drive, Suite 101, Myrtle Beach, S.C. 29577

Telephone: (843) 448-4820 / Fax: (843) 448-9875

E-mail: [cscinfo@coastalsamaritan.org](mailto:cscinfo@coastalsamaritan.org)

Website: [www.coastalsamaritan.org](http://www.coastalsamaritan.org)

## Financial Policy and Fee Agreement

**COST:** \$160.00 initial intake Effective 01/01/2018  
\$140.00 per clinical hour Effective 01/01/2018

**TERMS:** Payable when services are rendered. When appointments are first scheduled, clients are required to give the Center a valid Credit/Debit Card to hold the appointment. At each appointment, either at the beginning or end of each visit, each client is required to check out at the window before leaving. You will be asked to sign the Client Intake Signature Form, signifying your consent to this Financial Policy and Fee Agreement.

**PAYMENT:** Cash, Check, or Credit/Debit Card

**CREDIT/DEBIT CARD POLICY:** The person making the payment must have their card with them. The name on the card must be the name of the person making the payment, except in the case of a primary family member using the card with the permission of the cardholder. The card must be current and not have expired. All transactions must be authorized before processing.

**ACCOUNT BALANCES/DEFERRED PAYMENTS:** Subject to the approval of the Executive Director; you may request to remit regular payments to reduce the account balance. This is generally reserved for the following clients: Those who cannot make full payment in cash or check, those who do not have a credit card, or those who do not have medical insurance. Statements will be mailed each month for any accounts with a balance. Counselors will be expected to address responsible management of accounts with clients.

**INSURANCE COVERAGE:** Using insurance to pay for services is optional. If you wish to use your health insurance to pay for services, you must complete an **Insurance Information Form** and sign a **Release of Information and Assignment of Benefits** so that the Center can submit claims and receive payment for services. **The Center generally cannot approve a fee reduction since you are required by law to meet your deductible and make co-payments as your policy dictates.** However, every effort will be made to work with you until your deductible is met by deferring payment, if necessary. ***If the counselor you are seeing is not an approved provider for your insurance company, you have the option of: using out of network benefits if applicable; declining use of your insurance and negotiating a fee based upon income; or agreeing to reimburse the Center the same fee insurance allows.***

**FEE ADJUSTMENT:** The Coastal Samaritan Counseling Center, Inc. is a non-profit organization dedicated to offering professional counseling and psychotherapy to the community at an affordable cost. As such, the Center operates at a **minimum margin** between the cost of services and the fees charged for those services. If a client demonstrates an inability to pay full fee for therapy, every effort will be made to reasonably adjust the fee. Center policy dictates that **every client is expected to pay something for their therapy.** The fee is based upon a person's ability to pay, determined by these factors: total household income, number of persons in the household, availability of health insurance, and other extenuating circumstances such as loss of employment, recent separation/divorce, excessive medical expenses, bankruptcy, caring for elderly parents/dependent children, and excessive consumer debt. If you would like to be considered for a fee adjustment, please speak with your counselor at your first session. **You must complete the Adjusted Fee/Client Assistance Fund Application to be eligible for the fee adjustment. You must provide proof of income by bringing in a pay stub, W-2, or previous year's tax return to be eligible for a fee adjustment.** You and your counselor can negotiate a fair and reasonable fee at your first session. Coastal Samaritan Counseling Center is able to offer an adjusted fee program due to the donations made by the generosity of donors: private business, organizations, clubs, churches and individuals.

**CANCELLATION POLICY:** In the event that you need to miss a scheduled appointment, please extend the professional courtesy of cancelling as early as possible, so that the hour reserved for you may be offered to someone else needing profession counseling services.

---

Client Signature

---

Date



# Coastal Samaritan Counseling Center

## *Instilling hope and healing*

1297 Professional Drive, Suite 101, Myrtle Beach, S.C. 29577

Telephone: (843) 448-4820 / Fax: (843) 448-9875

E-mail: [cscinfo@coastalsamaritan.org](mailto:cscinfo@coastalsamaritan.org)

Website: [www.coastalsamaritan.org](http://www.coastalsamaritan.org)

## Financial Policy and Fee Agreement

**COST:** \$160.00 initial intake Effective 01/01/2018  
\$140.00 per clinical hour Effective 01/01/2018

**TERMS:** Payable when services are rendered. When appointments are first scheduled, clients are required to give the Center a valid Credit/Debit Card to hold the appointment. At each appointment, either at the beginning or end of each visit, each client is required to check out at the window before leaving. You will be asked to sign the Client Intake Signature Form, signifying your consent to this Financial Policy and Fee Agreement.

**PAYMENT:** Cash, Check, or Credit/Debit Card

**CREDIT/DEBIT CARD POLICY:** The person making the payment must have their card with them. The name on the card must be the name of the person making the payment, except in the case of a primary family member using the card with the permission of the cardholder. The card must be current and not have expired. All transactions must be authorized before processing.

**ACCOUNT BALANCES/DEFERRED PAYMENTS:** Subject to the approval of the Executive Director; you may request to remit regular payments to reduce the account balance. This is generally reserved for the following clients: Those who cannot make full payment in cash or check, those who do not have a credit card, or those who do not have medical insurance. Statements will be mailed each month for any accounts with a balance. Counselors will be expected to address responsible management of accounts with clients.

**INSURANCE COVERAGE:** Using insurance to pay for services is optional. If you wish to use your health insurance to pay for services, you must complete an **Insurance Information Form** and sign a **Release of Information and Assignment of Benefits** so that the Center can submit claims and receive payment for services. **The Center generally cannot approve a fee reduction since you are required by law to meet your deductible and make co-payments as your policy dictates.** However, every effort will be made to work with you until your deductible is met by deferring payment, if necessary. *If the counselor you are seeing is not an approved provider for your insurance company, you have the option of: using out of network benefits if applicable; declining use of your insurance and negotiating a fee based upon income; or agreeing to reimburse the Center the same fee insurance allows.*

**FEE ADJUSTMENT:** The Coastal Samaritan Counseling Center, Inc. is a non-profit organization dedicated to offering professional counseling and psychotherapy to the community at an affordable cost. As such, the Center operates at a **minimum margin** between the cost of services and the fees charged for those services. If a client demonstrates an inability to pay full fee for therapy, every effort will be made to reasonably adjust the fee. Center policy dictates that **every client is expected to pay something for their therapy.** The fee is based upon a person's ability to pay, determined by these factors: total household income, number of persons in the household, availability of health insurance, and other extenuating circumstances such as loss of employment, recent separation/divorce, excessive medical expenses, bankruptcy, caring for elderly parents/dependent children, and excessive consumer debt. If you would like to be considered for a fee adjustment, please speak with your counselor at your first session. **You must complete the Adjusted Fee/Client Assistance Fund Application to be eligible for the fee adjustment. You must provide proof of income by bringing in a pay stub, W-2, or previous year's tax return to be eligible for a fee adjustment.** You and your counselor can negotiate a fair and reasonable fee at your first session. Coastal Samaritan Counseling Center is able to offer an adjusted fee program due to the donations made by the generosity of donors: private business, organizations, clubs, churches and individuals.

**CANCELLATION POLICY:** In the event that you need to miss a scheduled appointment, please extend the professional courtesy of cancelling as early as possible, so that the hour reserved for you may be offered to someone else needing profession counseling services.

**Failure to give a reasonable twenty-four (24) hour notification for cancellations to the Center will result in a minimum charge of thirty-five dollars (\$35.00). I understand that a thirty-five dollar (\$35.00) fee will be charged for no- shows and it must be paid prior to scheduling the next appointment. Your credit card/debit card on file will be charged for the no-show/late cancellation fee.** For your convenience, the Center maintains a voice mail system that records messages 24 hour per day.





# Coastal Samaritan Counseling Center

*Instilling hope and healing*

901 N. Kings Hwy., Myrtle Beach, S.C. 29577  
Telephone: (843) 448-4820 / Fax: (843) 448-9875  
E-mail: cscinfo@coastalsamaritan.org

## Adjusted Fee/Client Assistance Fund Application

Adjusted Fee/Client Assistance Fund is available to those clients who are unable to pay full fee for counseling services. Proof of income must be provide prior to the first appointment.

### Proof of income includes:

- \* Copies of your two most recent pay stubs for each household wage earner.
- \* Copy of last year's tax return.
- \* Statement letter from homeless shelter.

**CANCELLATION POLICY:** In the event that you need to miss a scheduled appointment, please extend the professional courtesy of cancelling as early as possible, so that the hour reserved for you may be offered to someone else needing profession counseling services.

**Failure to give a reasonable twenty-four (24) hour notification for cancellations to the Center will result in a minimum charge of thirty-five dollars (\$35.00). I understand that a thirty-five dollar (\$35.00) fee will be charged for No-Shows and it must be paid prior to scheduling the next appointment. Your credit card/debit card on file will be charged for the No-Show/Late Cancellation Fee.** For your convenience, the Center maintains a voice mail system that records messages 24 hours per day.

Name(s) of Applicant(s) : \_\_\_\_\_

How many people live your household? Adults: \_\_\_\_\_ Children: \_\_\_\_\_

List ALL individuals in your household who contribute to the household income.

Name of Household Member	Employer	Monthly Gross Income

### Additional Income

Child Support	
Unemployment Wages	
Other types of verifiable income (Social Security, Disability, Retirement, Etc.)	

I certify that I have read and understand the above information and that information submitted is complete and accurate to the best of my knowledge.

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

### FOR OFFICE USE ONLY

PROOF OF INCOME PROVIDED: YES \_\_\_\_\_ NO \_\_\_\_\_ APPROVED: YES \_\_\_\_\_ NO \_\_\_\_\_

APPROVED FEE: \$ \_\_\_\_\_ by \_\_\_\_\_ DATE \_\_\_\_\_



# Coastal Samaritan Counseling Center

*Instilling hope and healing*

1297 Professional Drive, Suite 101, Myrtle Beach, S.C. 29577

Telephone: (843) 448-4820 / Fax: (843) 448-9875

E-mail: [cscinfo@coastalsamaritan.org](mailto:cscinfo@coastalsamaritan.org)

## Client Insurance Information Form

This form is required for all clients who are covered by insurance, EAP, or managed care benefits.

Clients's Name: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Card ID#: \_\_\_\_\_

Check one of the following: ☐ Insurance ☐ Managed Care ☐ EAP

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

---

Is there another health benefit plan or insurance company providing coverage? ☐ Yes ☐ No If yes complete the following:

Name of Insured: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize The Coastal Samaritan Counseling Center, Inc. and any member of the clinical staff of the Center to provide a summary of care and assessment information regarding evaluation and/or treatment for the purpose of evaluating and processing claims for benefits. Furthermore, I authorize payment of mental health benefits directly to The Coastal Samaritan Counseling Center, Inc. for services rendered. The Coastal Samaritan Counseling Center, Inc. will file my claim for me and re-file if necessary. I will make all co-payments in accordance with the adjusted fee scale if my insurance company delays or refuses to pay claims. The Coastal Samaritan Counseling Center, Inc. will make any necessary adjustments to my account when insurance payments are received. I understand the payment for services render is ultimately my responsibility.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Coastal Samaritan Counseling Center

## *Instilling hope and healing*

1297 Professional Drive, Suite 10, Myrtle Beach, SC 29577  
Telephone (843) 448-4820 / Fax: (843) 448-9875

### Client Intake Signature Form

Your signature indicates that you have read, understood and agreed to the terms in each document listed below. Your signature indicates that you have received a copy of the listed documents.

✓ **Therapy Information and Disclosure Form**

I have seen, read and received a copy of the Therapy Information and Disclosure Form. I consent to treatment as described in the Therapy Information and Disclosure Form. I, also, understand the limits of confidentiality.

✓ **Notice of Privacy Practices**

I have seen, read and received a copy of the Coastal Samaritan Counseling Center's Notice of Privacy Practices.

✓ **Professional Disclosure Statement for Counselor**

I have seen, read and received a copy of my counselor's Professional Disclosure Statement.

✓ **Authorization for Credit Card Charges**

I have seen, read and received a copy of the Authorization for Credit Charges Form.

✓ **Financial Policy and Fee Agreement**

**Failure to give a reasonable twenty-four (24) hour notification for cancellations to the Center will result in a minimum charge of thirty-five dollars (\$35.00). I understand that a thirty-five dollar (\$35.00) fee will be charged for no- shows and it must be paid prior to scheduling the next appointment.**

I have read, understood, and received a copy of the CSCC Financial Policy and Fee Agreement. I agree to pay the contracted fee at the time of service of each session. I understand that any subsidies received for my fees are contingent on contribution. If these contributions are not forthcoming, the center cannot provide the subsidy. I have read, understood and agreed with the conditions upon which my fee has been determined. I also understand that if and when my financial condition changes, either positively or negatively, I can renegotiate the adjusted fee by talking with my counselor.

Date: \_\_\_\_\_

Name (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_



# Coastal Samaritan Counseling Center

*Instilling hope and healing*

1297 Professional Drive, Suite 101, Myrtle Beach, S.C. 29577

Telephone: (843) 448-4820 / Fax: (843) 448-9875

E-mail: [cscinfo@coastalsamaritan.org](mailto:cscinfo@coastalsamaritan.org)

## Authorization for Credit Card Charges Form

**CANCELLATION POLICY:** In the event that you need to miss a scheduled appointment, please extend the professional courtesy of cancelling as early as possible, so that the clinical hour reserved for you may be offered to someone else needing professional counseling services. For your convenience, the Center maintains a voice mail system that records messages 24 hours per day.

**Failure to give a reasonable twenty-four (24) hour notification for cancellations to the Center will result in a minimum charge of thirty-five dollars (\$35.00). I understand that a thirty-five dollar (\$35.00) fee will be charged for No-Shows and it must be paid prior to scheduling the next appointment.**

**Your credit card/debit card on file will be charged for the No-Show/Late Cancellation Fee.**

You will be charged on the day that you miss your therapy appointment unless other arrangements have been made. The charge will be made under the name **Coastal Samaritan Counseling Center**. You agree that no prior notification is necessary other than this signed document. In addition, outstanding therapy charges will also be billed to this card, unless other arrangements have been made.

Clients's Name(please print): \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Account Type: ☐ Visa ☐ MasterCard Credit Card#: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV (3-digit number on back of card): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

I authorize Coastal Samaritan Counseling Center to charge this credit card for professional services and/or other charges as agreed above. These charges may include: No Show/Late Cancellation Fee of \$35.00 and other outstanding therapy charges for which arrangements with the Center have not be made.

I understand that this authorization will remain in effect until I cancel it in writing and I agree to notify Coastal Samaritan Counseling Center in writing of any changes in my account information or termination of this authorization as soon as possible.

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