Samaritan Counseling Center - CFS Client Information

Date _____

(Last Name) (First Name) (Middle or Initial)

Date of Birth_____/_____/_____ Age_____ **Male** ◯ **Female** ◯

Address_____City_____Zip_____

Cell/Home Phone _____ OK to call? ☐ Alternate phone_____ OK to call? ☐

Email_____ Ok to contact? ◯ Ok to receive communication/newsletter? ◯

Who is the responsible billing party? **Children and Family Services**

Name of Parent or legal guardian (if under 18):_____

Demographic Statistical Information

Ethnic Background: African American ☐ Asian/Pacific Islander ☐ American Indian ☐ Hispanic/Latino ☐ White/Caucasian ☐ Other/Multi-Racial ☐ Unknown ☐		
Do you attend church? Y ◯ N ◯ Name of Church:		
Marital Status: Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Other (Specify):		
Total Yearly Household Income:	# of people in your household (including yourself):	# of children living with you under age 18:

SAMARITAN COUNSELING CENTER

Serving Individuals, Couples, and Families since 1973
Doug McKown, Psy.D., Executive Director

CONSENT FOR RELEASE OF INFORMATION OR RECORDS

This Release is regarding _____ DOB: __/___/__
Clients Name (print) (Date of Birth)

A. TO ANOTHER PROFESSIONAL OR AGENCY:

I hereby authorize the Samaritan Counseling Center to release information/records regarding the above named client to:

San Bernardino County Children and Family Services

_____

Address *Phone Number*

B: TO THIS CENTER:

I hereby authorize **Children and Family Services**
Name of professional or agency

To release information/records regarding the above named client to the Samaritan Counseling Center, 1126 W Foothill Blvd., Suite 110, Upland, CA 91786.`

C: PURPOSES:

These records are all protected by the California Welfare and Institution Code, Section 5328. Disclosure shall be limited to the information specified below:

Check appropriate items:

- ☐ Diagnosis
- ☐ Psychological assessment/evaluation
- ☐ Treatment summary
- ☐ Progress notes
- ■ Verification of Attendance
- ■ Other: Only information necessary for invoice and contract monitoring at any point in time

D. DATES:

This authorization shall become effective on __/____/___

The consent shall terminate on ____/____/____

Note: Unless otherwise stated, this authorization will terminate automatically, one year from the effective date. You also have the right to revoke in writing this authorization at any time. (Except invoice and contract monitoring does not expire)

SIGNATURES:

____/_____/_____ _____
Date **Client Name (Print)**

_____ _____
Witness **Signature Client or Parent/Guardian**
(Indicate relationship if client is a minor)

SAN BERNARDINO COUNTY | Human Services

COMPLAINT AND GRIEVANCE PROCEDURE

INSTRUCTIONS: THE CUSTOMER IS TO READ AND RECEIVE THE TOP PORTION OF THIS FORM. THE BOTTOM PORTION OF THE FORM IS TO BE SIGNED BY SERVICE RECIPIENT AND PLACED IN THE CONTRACTOR'S RECORDS.

If you believe you have been discriminated against, or that there has been a violation of any laws or regulations, or if you have a problem regarding services received, you have the right to file a complaint or tell us your grievance.

The following procedures are to be followed when filing a complaint or grievance.

STEP ONE:
Write down your complaint or grievance and talk to the service provider. Keep a copy for yourself and write down the date you talked to the service provider.

- If answered or resolved at this step, nothing further is required.
- If no answer or resolution within 10 calendar days, proceed with Step Two.

STEP TWO:
Send a copy of your written complaint or grievance, or discuss the complaint or grievance with your County Caseworker. Write down the date you spoke to your Caseworker or send the complaint and keep it with your copy.

- If answered or resolved at this step, nothing further is required.
- If no answer or resolution within 10 calendar days, proceed with Step Three.

STEP THREE:
Send a copy of your written complaint or grievance to the Program Specialist. If you would like a response, include your name, address and telephone number. Your personal information and your complaint and grievance details will be kept confidential.

HS Program Development Division, Contracts Support Unit
ATTN: Program Specialist
825 E. Hospitality Lane, 2nd Floor
San Bernardino, CA 92415-0079

- If answered or resolved at this step, nothing further is required.
- If no answer or resolution within 10 calendar days, proceed with Step Four.

STEP FOUR:
Send a copy of your written complaint or grievance to the Contract Analyst at:

HS Administrative Support Division, ATTN: Contracts Unit
150 S. Lena Road
San Bernardino, CA 92415-0515

You will be contacted within 10 calendar days if you have provided contact information.

Please note: Each of these steps must be completed in the sequence shown.

. . . . . **Detach here** . . . . .

COMPLAINT AND GRIEVANCE PROCEDURE CERTIFICATION

This certifies I have read, understood, and received the Complaint and Grievance Procedures.

Client Signature _____ Date _____

SAMARITAN COUNSELING CENTER

Consent to Treatment/Client's Rights

THE AGENCY: The Samaritan Counseling Center was founded in 1973 to meet an expressed need for community-based counseling. Many churches in our community support the Center as an outreach of their ministry to hurting persons. Our nonprofit status and other community funding enable us to offer to you high quality counseling at affordable rates.

THE THERAPISTS: Our therapists are highly qualified as generalists and also have advanced training in an additional area of specialty. They each are involved in ongoing training in order to be informed of the latest developments and theories in their particular fields.

CONFIDENTIALITY: All counseling done in our offices is held in strict confidence. We will consult with other professionals (i.e., your physician, pastor, teacher) only after you have given us written permission to do so. In the event that your therapy is provided by an intern, your case will be supervised by the appropriate professional supervisor. If we need to phone you at home or at work, we will identify ourselves by using a first name only.

LIMITATIONS TO CONFIDENTIALITY: State law requires that confidentiality be suspended and information disclosed to avoid danger to others when:

1) The therapist thinks that a client is genuinely threatening bodily harm to another. The therapist must warn the intended victim and notify the police.
2) When a therapist has reasonable knowledge that a person over age 65 or a dependent adult has been physically abused.
3) The therapist suspects or has direct knowledge that a child is or has been sexually abused, physically abused or neglected. The therapist must report to a child protective agency.
4) The therapist thinks that a client is making a genuine threat to do bodily harm to himself/herself, and/or the therapists thinks that a client is gravely disabled and thus incapable of caring for himself/herself. The therapists must then take active steps to insure that the client's well-being is taken care of by outside agencies.
5) To input demographic information into the County's secure database for purposes of invoicing.

EMERGENCIES: The Samaritan Counseling Center is not a crisis counseling center nor do we maintain a 24-hour crisis hotline. The phone is answered in the business office between the hours of 8:30 a.m. and 5:30 p.m. Monday through Friday. An answering machine is in place during non-business hours for clients to leave messages pertaining to scheduling or canceling appointments. If, in your particular situation, you anticipate needing to reach your therapist on an emergency basis, please make this need known to our therapist at this initial appointment so appropriate arrangements can be made prior to a crisis arising. Otherwise, we recommend telephoning 911.

Your signature below indicates that you have read and understand these provisions, and that you are giving consent for treatment here at the Samaritan Counseling Center.

Your signature below also indicates that you have reviewed a copy of the center's Notice of Privacy Practices and Grievance Procedures.

_____

Signature of Client Date (Relationship if other than counselee)

SAMARITAN COUNSELING CENTER

A Brief Family History:

Name _____ Date _____

Date of Marriage, if any _____ Spouse's name _____

Date(s) of previous marriages (s) _____

Your father's/stepfather's name _____ Age _____

Your mother's/stepmother's name _____ Age _____

List your children: (If child is client list siblings)

First Name	Gender	Age	Living?	Marital Status

Overall how would you rate your health?

Excellent _____ Good _____ Fair _____ Poor _____

List any serious illness you currently have:

_____

Significant Hospitalizations:

_____

Current physician, and telephone :

_____

Please list any medications you're currently taking, their dosage, and purpose:

_____

_____

Are you currently receiving mental health services somewhere else?

_____

Are you currently participating in an alcohol or substance program?

_____

Are these counseling services court ordered or a condition of any probation?

_____

SAMARTIAN COUNSELING CENTER

SELF ASSESSMENT FORM

Name _____ Staff _____

Age _____ Gender: M F

Today's Date _____

	Never	Rarely	Sometimes	Frequently	Almost Always
1 I have trouble falling asleep or staying asleep	0	1	2	3	4
2 I feel stressed at work, school or other daily activities	0	1	2	3	4
3 I blame myself for things	0	1	2	3	4
4 I am satisfied with my life	0	1	2	3	4
5 I feel resentful	0	1	2	3	4
6 I have thoughts of ending my life	0	1	2	3	4
7 I feel overwhelmed	0	1	2	3	4
8 I find my work/school or other daily activities satisfying	0	1	2	3	4
9 I have difficulty communicating clearly	0	1	2	3	4
10 I feel worthless	0	1	2	3	4
11 I am concerned about family troubles	0	1	2	3	4
12 I feel sad	0	1	2	3	4
13 I have frequent arguments	0	1	2	3	4
14 I have difficulty concentrating	0	1	2	3	4
15 I feel hopeless about my life	0	1	2	3	4
16 I worry a lot	0	1	2	3	4
17 People criticize my drinking (or drug use)	0	1	2	3	4
18 I have trouble getting along with friends and close acquaintances	0	1	2	3	4
19 I have trouble at work/school or other daily activities because of drinking or drug use	0	1	2	3	4
20 I feel that something bad is going to happen	0	1	2	3	4
21 I feel nervous	0	1	2	3	4
22 I am troubled about my past	0	1	2	3	4
23 I feel hurt when I think about how my life has gone	0	1	2	3	4
24 I feel forgiven	0	1	2	3	4
25 I am satisfied with my relationships with loved ones	0	1	2	3	4

If you wish, please describe any additional concerns which you bring to counseling