PO Box 914
21641 Great Mills Road
Lexington Park, MD 20653
Phone: 301-863-9333
www.pccstmary.org

Pastoral Counseling Center of St. Mary's Inc.

Federal ID # 52 1337356
MD Registration # 14839
MD State ID # D01620715
Maryland Charity Campaign
MCC # 4303
United Way CFC# 32593

Client Intake Information Form

General Information

Last Name: _____ First Name: _____ Middle Initial: _____
Birth Date: ____/____/____ SS#: _____ ☐ Male ☐ Female
Street Address: _____ Apt # _____
City: _____ State: _____ Zip: _____
Home Telephone: (____) _____ Work Telephone: (____) _____ Cell # _____
If client is a minor: Name/Address/Phone of custodial parent, if different from name of financially responsible person:
_____
In Emergency Notify: _____ Phone: _____ Relationship: _____
How did you learn about the Center? ☐ Yellow Pages ☐ Pastor/Church Literature ☐ Physician ☐ Employer ☐ Sign ☐ Friends/Acquaintances ☐ Family ☐ Other _____
Name and Address of person who referred you to PCC? _____
May we send a thank you letter to that person as a courtesy? ☐ Yes ☐ No
Please add me to the PCC mailing list ☐ Yes ☐ No
Reason for choosing this Center: _____
Your congregation / church / temple: _____
☐ Check if spirituality is important for you to have addressed or included in your therapy.
Your racial / ethnic identity: ☐ African-American ☐ Native-American ☐ Asian-American ☐ White ☐ Hispanic ☐ Other

Employment / Education Information

Full-time employee _____ Part-time employee _____ Self employed _____ Unemployed _____
Place of employment / school (if student): _____
Type of work you do: _____ Gross Annual Family Income: _____
Highest level of education completed: ☐ High School ☐ Some College ☐ College Degree ☐ Bachelors's Degree ☐ Graduate Degree ☐ Professional Training ☐ Other: _____

Family Information

Relationships: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Cohabiting
Parents: *Mother:* ☐ Living, age _____ ☐ Deceased *Father:* ☐ Living, age _____ ☐ Deceased
Sibling: Number of *Brothers* _____ Number of *Sisters* _____ ☐ Only Child
List ages of *brothers* [_____] of *sisters* [_____]
Names and ages of your *Children:* _____
_____
_____ Have any of your children died? _____

Identity Verification (Red Flag Rule Compliance)

Completed by PCC Staff member

Verified by: _____ Date: _____
Drivers License/State ID ☐ Yes ☐ No Other Photo ID ☐ Yes ☐ No
Student ID (child) ☐ Yes ☐ No Parent's ID (child) ☐ Yes ☐ No

Problem Definition

What is your reason for seeking help now? _____

_____

Are any of the following conditions a problem to you at this time? (Check the ones that apply)

- ☐ Anxiety
- ☐ Grief
- ☐ Depression
- ☐ Irrational fears
- ☐ Nervousness
- ☐ Loneliness
- ☐ Anger
- ☐ Marriage problems
- ☐ Sexual concerns
- ☐ Loss of work/job

- ☐ Self esteem
- ☐ Stress
- ☐ Substance abuse
- ☐ Chronic fear
- ☐ Guilt feelings
- ☐ Suicidal feelings
- ☐ Loss of hope
- ☐ Rage
- ☐ Relationship with parents
- ☐ Relationship with children

- ☐ Loss of meaning in life
- ☐ Loss of faith in God
- ☐ Conflicts at work
- ☐ Religious doubts
- ☐ Other (list)

_____

_____

_____

_____

_____

Make a check mark if any of these statements are true.

- ☐ I have thoughts of harming myself or others.
- ☐ Thoughts of harming myself or others is a frequent occurrence.
- ☐ I dwell on these thoughts and wonder if I can control them.
- ☐ I Have sought professional help because of these thoughts or feelings.

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

_____

Medical/Psychological History

Name of your physician: _____

It is our practice to coordinate care with one's physician when this would be helpful. If you agree that we may contact your physician please check here: ☐ (*Please sign a release of information form for this purpose.)*

When was your last medical examination? _____

Are you suffering any physical illnesses or symptoms at this time? _____

_____

List major surgeries or illnesses in the last five years: _____

_____

_____

List current medications: _____

_____

Have you or any member of your family received help for drug or alcohol dependency? ☐ Yes ☐ No

When? _____ Name of helping agency: _____

Have you received psychotherapy or counseling in the past? ☐ Yes ☐ No When? _____

Name of treating therapist: _____

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.

_____ _____

Client's Signature Date

PO Box 914
21641 Great Mills Road
Lexington Park, MD 20653
Phone: 301-863-9333
www.pccstmary.org

Pastoral Counseling Center of St. Mary's Inc.

Federal ID # 52 1337356
MD Registration # 14839
MD State ID # D01620715
Maryland Charity Campaign
MCC # 4303
United Way CFC# 32593

CLIENT AGREEMENT & CONSENT FOR TREATMENT FORM

Please read the following before signing below:
I have read and understood the information contained in the Information about PCC Services document.
In signing this Client Agreement and Consent for Treatment form, I acknowledge that:

- I do hereby consent to treatment by the Pastoral Counseling Center of St. Mary's, Inc.
- I voluntarily enter into therapy with the therapist whose name is listed below.
- I may withdraw from treatment at any time unless treatment is mandated by court.
- I am 18 years of age or over and have not been declared incompetent by a court of law, or
- I am the parent/legally-appointed guardian or authorized representative of the client to be treated who is 17 years of age or younger, or
- Although under the age of 18, I am legally empowered to consent to treatment per the conditions outlined in the Code of Maryland Regulations (COMAR). Under Maryland law, a minor (anyone under 18 years of age) can consent to medical treatment under the following conditions:
  - You are married;
  - You have a child;
  - You have an emergency (i.e., when any delay in obtaining consent from someone else will harm your health;
  - You want specific treatment or advice about drug abuse, alcohol abuse, sexually transmitted diseases, pregnancy or contraception;
  - You need a physical exam and treatment for injuries from an alleged rape or sexual offense;
  - You need a physical exam to obtain evidence of an alleged rape or sexual offense: or
  - You need an initial medical screening and physical exam after being admitted into a detention center.
- I acknowledge that I am financially responsible to PCC as described in Information about PCC Services document.

I further acknowledge the following:

- I understand therapy is a joint endeavor between the therapist and client, the results of which cannot be guaranteed. Progress depends on many factors, including commitment, motivation, effort and life circumstances.
- If my therapist believes counseling is not appropriate for me at this time, or that I should be referred elsewhere, I will be so informed.
- I understand effective counseling involves my regular attendance at scheduled counseling sessions and talking openly with my counselor.
- My therapist will inform me of possible risks in my seeking therapy and will work with me in determining an appropriate course of treatment.
- I understand my right to have simple, clear explanations for treatment recommendations. I have the right to refuse recommendations.
- I have been informed that my therapist _____ is a [ ] Staff Therapist [ ] Therapist Intern.

This form is an agreement between _____ and PCC.

I acknowledge that the information contained in the Client Agreement and Consent for Treatment Form has been made available to me, explained to me, or read by me and that it was presented in clear, non-technical language. My signature affirms that the information is understood by me and enables me to make an informed voluntary consent to therapy.

If client is a minor: I give permission for this minor child to receive therapy and for this minor child to receive therapy without a parent or guardian present. Print Client's Name: _____

_____	_____	_____
Signature of Client, Parent, Guardian or Representative	Date	Authority to Represent Client
_____	_____	_____
Signature of Client, Parent, Guardian or Representative	Date	Authority to Represent Client

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required.* Only one parent's signature is required if parents are married to each other.

_____	_____
Signature of PCC Staff	Date

I hereby authorize the PCC to use or disclose my Health Information for the following purposes:

- **Payment:** Written authorization is not required for the PCC to contact you regarding payment for services. However, we request your cooperation in letting us know where to contact you for billing purposes.
- **Operations:** To receive appointment and reminder calls.

I authorize PCC to contact me in the following ways:

By Phone

☐ At Work ☐ Voicemail at Work ☐ Cell Phone ☐ Cell Phone Voicemail

☐ At Home ☐ Voicemail at Home ☐ I prefer not to receive calls

☐ Leave a message with _____ Phone # _____

By Mail (for purposes of billing and notifications)

☐ At Home

☐ Alternative mailing address if home address declined_____

By Email (confirmation of appointments and billing)

☐ Address 1: _____

☐ Address 2: _____

I understand that electronic means of communication may be unsecure and that the Pastoral Counseling Center of St. Mary's, Inc. (PCC) cannot guarantee confidentiality with electronic communications. It is important that you understand that the nature of the Internet is that any e-mails you send or receive may also be intercepted by other people. Therefore, if you send your therapist an e-mail, or if you ask your therapist to respond to you about something via an e-mail, you must understand that it is not entirely confidential and may be intercepted by others. The email services used by PCC are HIPAA compliant.

I understand that this authorization is in effect until my case is closed by PCC or until I revoke it in writing.

I hereby acknowledge that:

- **I have read and understand the information contained in this consent and that I am the Client or am authorized to act on behalf of the client to sign this document verifying consent to the above stated terms.**
- **A copy of PCC's *Notice of Privacy Policies* has been offered to me. I am also aware that copies are posted in the waiting area for review.**

Disclosure Statement: This information is required by the Board of Professional Counselors and Therapists, which regulates all licensed and certified counselors and therapists.

Board of Professional Counselors:
4201 Patterson Avenue, Baltimore, MD 21215-2299
(410) 764-4732

Print Client's Name: _____

_____	_____	_____
Signature of Client, Parent, Guardian or Representative	Date	Authority to Represent Client
_____	_____	_____
Signature of Client, Parent, Guardian or Representative	Date	Authority to Represent Client

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required..* Only one parent's signature is required if parents are married to each other.

_____	_____
Signature of PCC Staff	Date

PO Box 914
21641 Great Mills Road
Lexington Park, MD 20653
Phone: 301-863-9333
www.pccstmary.org

Pastoral Counseling Center of St. Mary's Inc.

Federal ID # 52 1337356
MD Registration # 14839
MD State ID # D01620715
Maryland Charity Campaign
MCC # 4303
United Way CFC# 32593

CLIENT ASSISTANCE PLAN: FEE AND CANCELLATION POLICY

SLIDING SCALE FEES

- Fees are set in consultation with client
- Fees are based on income and need
- Standard fee is $120.00
- All fees below base fee will be reviewed on a 6 month basis.
- All fees will be reviewed annually.

CLIENT ASSISTANCE PLAN

- Available on limited basis for clients unable to pay fee
- Appropriately signed request for fee consideration
  - 2 most recent pay stubs or W2
  - If self employed 2 recent bank statements, savings and checking and /or 1099
  - Worksheet documenting income and expenses to support request for fee consideration
  - Explore options for reimbursement from insurance. Determine co-pay for out of network provider and consider accepting co-pay if the client does not wish to deal with reimbursement or let provider know that they are in counseling.

INSURANCE CLAIMS

- Receipts issued upon request for clients to submit for reimbursement, we cannot guarantee reimbursement
- Client will do all other paperwork associated with this effort

ACCEPTABLE FORMS OF PAYMENT

- We accept, Cash, Checks, Money Orders or payment through PayPal

LATE CANCELLATION FEES

- Clients will be charged for sessions cancelled with less than 24 hours notice

RETURNED CHECK FEES

- Client responsible for paying for returned check
- Client responsible for Returned Check fees of $25.00
- Payment for returned checks may be in cash or a money order

I have reviewed the fee and cancellation policy stated above.

Signature of Client, Parent, Guardian or Representative	Date	Authority to Represent Client

FEE AGREEMENT

Our Standard fee is $120 per 50 - 60 minute session

☐ Self-Pay	$120.00	Client will pay full fee for service
☐ Sliding Scale	$	Client will pay sliding scale fee for service
☐ Client Assistance Plan Fee		Client will pay less than minimum fee on sliding scale
☐ EAP Coverage	for 1st	sessions; self pay to be negotiated after completion EAP

Additional fees may be charged for written reports (e.g. for court proceeding, etc.). These charges will be based on standard fee of $120.00 per hour.

Client's Consent to Fee Agreement

1. I understand that the Standard Fee is the contracted fee unless fee negotiated under sliding scale guidelines.
2. I agree to pay the contracted fee at the time of service, unless otherwise negotiated
3. The Client Assistance Plan subsidy for my fees is contingent on available funds for PCC and my submitting a signed request for fee consideration and the following documentation of need:
   - 2 most recent pay stubs or W2
   - If self employed 2 recent bank statements, savings and checking and /or 1099
   - Worksheet documenting income and expenses to support request for fee consideration
   - Explore options for reimbursement from insurance.
   - Determine co-pay for out of network provider may accept co-pay if the client does not wish to deal with reimbursement or let provider know that they are in counseling.
4. I have read and understand the conditions upon which my fee has been determined, and I agree to these conditions.

Print Client's Name: _____

Signature of Client, Parent, Guardian or Representative	Date	Authority to Represent Client
Signature of Client, Parent, Guardian or Representative	Date	Authority to Represent Client

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required.* Only one parent's signature is required if parents are married to each other.

Signature of PCC Staff	Date

PO Box 914
21641 Great Mills Road
Lexington Park, MD 20653
Phone: 301-863-9333
www.pccstmary.org

Pastoral Counseling Center of St. Mary's Inc.

Federal ID # 52 1337356
MD Registration # 14839
MD State ID # D01620715
Maryland Charity Campaign
MCC # 4303
United Way CFC# 32593

CLIENT ASSISTANCE PLAN: REQUEST FOR FEE CONCESSION

I. DEMOGRAPHICS

Name:_____ SSN:_____

DOB:_____ Sex:_____ Applicant lives with: ☐ Spouse ☐ child ☐ parent(s) ☐ alone ☐ other_____

Address:_____ Phone:_____

_____

Marital Status:_____ Children & Ages:_____

Employer:_____ Occupation:_____

Fee Requested: _____ Fee Authorized _____ By_____ Date _____

II. FISCAL INFORMATION

Income

Does applicant have:	Yes	No	Pending		
Medicare	____	____	_____	Co-pay for specialist_____	expiration_____
SSDI/SSI	____	____	_____	Amount_____	
Earned Income	____	____	Average Monthly Income_____		
Food Stamps	____	____	Amount_____ _____		
Insurance	____	____	Co-pay for specialist_____	Company_____	
Other	____	____	Amount_____		
Spouse Income	____	____	Average Monthly Income_____		

A. Expenses

Does applicant have:	Yes	No	Pending	
Medical Bills	____	____	_____	Monthly Payments_____
Legal Bills	____	____	_____	Monthly Payments_____
Child Support	____	____	_____	Amount_____
Credit Card Debt	____	____	Average Monthly Payments_____	
Special Food Costs	____	____	Amount per month_____ _____	
Rent/Mortgage	____	____	Amount per month_____	
Utility Bills	____	____	Amount per month_____	
Other	____	____	Amount_____	
Loans	____	____	Amount_____	Lender contact Info_____

_____ _____ _____

Signature of Client, Parent, Guardian or Representative Date Authority to Represent Client

_____ _____ _____

Signature of Client, Parent, Guardian or Representative Date Authority to Represent Client

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required.* Only one parent's signature is required if parents are married to each other.

_____ _____

Signature of PCC Staff Date