Arcadia Counseling CENTER

NEW CLIENT INFORMATION

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

Client's Preferred Name and Pronouns: _____

Address: _____
(Street) (City, State) (Zip Code)

Home Phone: _____ Work/Cell: _____

Permission to contact you at either number by phone or text? ☐ Yes ☐ No

E-mail: _____ Gender: ☐ Male ☐ Female ☐ Non-Binary

Emergency Contact: _____
(Full name) (Phone number) (Relationship to client)

Relationship Status: (Please circle one) Single Married Divorced Separated Domestic Partner Widowed

Name of parent(s) or legal guardian(s) for minor: _____

Please list others living in your household:

_____ _____
(Full name) (Relationship to client)

_____ _____
(Full name) (Relationship to client)

_____ _____
(Full name) (Relationship to client)

Primary Care Physician: _____ Phone: _____

May we contact your PCP to coordinate care? ☐ Yes ☐ No

Psychiatrist Name: _____ Phone: _____

May we contact your Psychiatrist to coordinate care? ☐ Yes ☐ No

Client's highest level of education: (Please circle one) High School College Graduate School

Client's Occupation: _____

How did you hear about Arcadia Counseling Center? _____

Arcadia Counseling CENTER

1. Have you ever received mental health treatment before? If so, when and by whom:

_____

_____

2. Is there any history of mental illness in your family? If so, please describe:

_____

3. Please list any medications you're currently taking:

_____

_____

4. Do you use alcohol, drugs or medications to get "high"? If so, please list the frequency of use:

_____

_____

5. Do you use tobacco/nicotine or caffeine? _____

6. Have you ever thought about or attempted self-harm or suicide? Do currently want to hurt yourself or someone else? If yes, please explain when the last thought/attempt was:

_____

_____

7. Please indicate how each of the following issues are affecting your life at this time:

	No effect	Little Effect	Much Effect	Significant Effect	Not Applicable
Marriage/Relationship	0	1	2	3	N/A
Family	0	1	2	3	N/A
Job/School Performance	0	1	2	3	N/A
Friendships	0	1	2	3	N/A
Financial Situation	0	1	2	3	N/A
Physical Health	0	1	2	3	N/A
Anxiety level/Nerves	0	1	2	3	N/A
Mood	0	1	2	3	N/A
Eating Habits	0	1	2	3	N/A
Sleeping Habits	0	1	2	3	N/A
Sexual Functioning	0	1	2	3	N/A
Alcohol/Drug Usage	0	1	2	3	N/A
Ability to concentrate	0	1	2	3	N/A
Ability to control anger	0	1	2	3	N/A

8. Why are you seeking treatment at this time?

_____

9. What goals do you want to accomplish / what outcomes do you expect from treatment?

_____

AUTHORIZATION AGREEMENT FOR RECURRING AUTOMATED CLEARING HOUSE TRANSCATIONS (ACH DEBITS)

Merchant: Arcadia Counseling Center
4647 N. 32nd Street, Ste. B-175
Phoenix, AZ 85016
602-218-6901

Client: _____

In consideration for the services provided to Client by ACC and in order to satisfy any outstanding debt due from Client(s) to ACC related to the same, I hereby authorize ACC to initiate recurring debit entries to our checking account indicated below at the depository financial institution named below, and to debit the same to such account for the amount(s) listed below. I acknowledge that the origination of ACH transactions to our account must comply with the provisions of United States law.

Financial Institution: _____

Account Number: _____

Routing Number: _____

Amount authorized: $ /50-minute session; $115/90-minute group

Date authorized: _____

This authorization is to remain in full force and effect for the terms of the engagement or until the total outstanding debt is paid in full, whichever is longer. The debit to the account authorized herein may only post on or after the date listed above.

This authorization may only be revoked by contacting ACC directly at the address and phone number listed above, and only in the case that the engagement is terminated and the total outstanding debt owed to ACC is paid in full.

Signature: _____

Printed Name: _____

Clinician: _____

There will be a $10 fee for every declined or nonsufficient fund transaction. It is the client's responsibility to update billing information on file in person with the clinician or over the phone with the office manager.

CANCELLATION POLICY

Cancellation of a previously scheduled appointment requires 24-hour notice.
If advanced notice is not given, the client will be responsible to pay the full amount for the missed appointment. All appointments are booked exclusively. "No-shows" or "forgotten" appointments will also result in the client being responsible for full payment as it prevents openings for other clients. A "No-show" fee of $50 will apply to intakes.
Initial: _____

INSURANCE REIMBURSEMENT

ACC can provide you with a receipt in the form of a superbill for your insurance reimbursement (monthly, quarterly, or annually); the fee amount, a diagnosis code, our tax ID, and clinician information will be included. It is **NOT** our responsibility to file claims on your behalf, or to confirm whether your insurance company will reimburse you out of network services. We recommend that you contact your insurance carrier directly to inquire about services covered, the number of sessions covered, and the turn-around time for reimbursement. If using a Health Savings Account (otherwise known as HSA card), please make sure funds are available at the time of billing.
Initial: _____

_____ _____
Client/Parent Signature Date

_____ _____
Arcadia Counseling Center, LLC Signature Date

FEE AGREEMENT FOR COUPLES/FAMILES

Counseling fees must be paid at the time of service. We accept cash, check, or credit/debit.

The initial couples' evaluation will be charged at the rate of $295.00 for 80 minutes. Each 50-minute session thereafter will be charged at the rate of $200.00 or $260.00 for 80 minutes. Rates to review documentation or to prepare written reports will be charged at $90.00 per half hour. Time spent on the telephone and e-mail outside of scheduled appointments may also be billed at a rate equal to an in-office session. A $3.00 service fee will be applied to all card transactions. Initial:_____

Payment can be made via use of a Credit/Debit card: □ Visa □ Master □ Discover □ AmEx

Name on Card:_____ Card #:_____

Billing Address:_____

Expiration: _____ /_____ Email Address: _____

There will be a $5 fee for every declined or nonsufficient fund transaction. It is the client's responsibility to update billing information on file in person with the clinician or over the phone with the office manager.

Although a valid card must always remain on file, you may choose to pay with check or cash in session. Exact cash is appreciated. Overpayment will be applied as credit.

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Initial: _____

INSURANCE REIMBURSEMENT

ACC can provide you with a receipt in the form of a superbill for your insurance reimbursement (monthly, quarterly, or annually); the fee amount, a diagnosis code, our tax ID, and clinician information will be included. It is **NOT** our responsibility to file claims on your behalf, or to confirm whether your insurance company will reimburse you out of network services. We recommend that you contact your insurance carrier directly to inquire about services covered, the number of sessions covered, and the turn-around time for reimbursement. If using a Health Savings Account (otherwise known as HSA card), please make sure funds are available at the time of billing.
Initial: _____

_____ _____
Client/Parent Signature Date

_____ _____
Arcadia Counseling Center, LLC Signature Date

CONSENT FOR EVALUATION/TREATMENT
(TO USE AND DISCLOSE HEALTH INFORMATION)

I, _____ (client/parent/guardian), voluntarily apply for evaluation/treatment at Arcadia Counseling Center, understand consent, and agree to the items listed below on behalf of _____ (self/minor).

a.) I have been provided with the intended outcome, nature and procedures involved in the proposed treatment, the risks of not proceeding and alternatives to the proposed treatment; I understand that consent may be withheld or withdrawn at any time with no punitive action taken.
b.) Limits of Confidentiality - ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, I understand that there are certain situations in which the therapist is required by law to reveal information obtained during therapy to other persons or agencies without my permission. The therapist is not required to inform me of their actions in this regard. These situations are as follows: (a) if I threaten grave, bodily harm, or death to another person, the provider is required by law to notify the appropriate parties or authorities; (b) if a court of law issues a legitimate court order (signed by a judge), the therapist is required by law to provide the information specifically described in that order; (c) If I reveal information relative to child abuse, child neglect, or elder abuse, the therapist is required by law to report this to the appropriate authority; (d) If I am in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; (e) Disclosure is required by the Arizona Board of Behavioral Health Examiners; (f) to comply with the USA Patriot Act and other federal, state or local laws, and (g) If I am seeking payment through an insurance company, the therapist will be required to reveal confidential information to them (each insurer is different in what information they require). There may be a time when paths cross outside of the therapy, and the therapist will maintain confidentiality by not making the initial gesture. It will be understood that neither party is being rude, but simply maintaining the therapeutic boundary. I am welcome to approach the therapist, although I will keep conversation minimal, again to maintain privacy. There may be a time when group members may cross paths of other group members; keep interaction to a minimum unless desired by both parties. In either case, I will be respectful by not revealing anything related to group.
c.) I consent to the use and disclosure of my protected health information (PHI) by Arcadia Counseling Center (ACC) and its staff members, for the purpose of treatment, payment and health care operations. This is a joint consent from between ACC and its staff. I understand the following: My signature on the Consent is required in order for me to receive care from ACC; I have the right to revoke this Consent, in writing, at any time, except to the extent that ACC has taken action in reliance upon this Consent;
I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of ACC. I realize that ACC is not required to agree to a restriction that I request. If, however, ACC does agree, the restriction must be honored by ACC; I have the right to review the Notice of Privacy Practices (attached) prior to signing this Consent. The Notice may be changed at any time and I can receive a copy of the revised Notice through my provider. ACC agrees to maintain my PHI in accordance with the practices in its Notice of Privacy Practices. This notice also explains my rights with respect to the use and disclosure of my PHI.
d.) Your evaluation and/or treatment may be staffed between behavioral health professionals within ACC.
e.) Treatment is individualized to specific needs and may result in emotional discomfort through the healing and recovery process.
f.) I agree to participate in my treatment planning process to the best of my ability.
g.) I understand that there is no guarantee that those treatment services prove beneficial to me.
h.) I understand that if participating in group treatment, all information discussed relating to other clients in sessions is confidential and may not be shared outside of group.

We are required by law to protect your PHI and to abide by the terms of the Notice of Privacy Practices and to provide you with information regarding ACC's privacy policies and practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. We will provide you with any revised Notice of Privacy Practices.

I have reviewed and understand the abovementioned Consent to Treatment and/or Evaluation and to Use and Disclose Health Information, and can request to review the Notice of Privacy Practices, and hereby consent to the evaluation and treatment provided by Arcadia Counseling Center, LLC.

_____ _____
Client Signature **Date**

_____ _____
Parent/Legal Guardian Signature (if applicable) **Date**

_____ _____
Arcadia Counseling Center, LLC Signature **Date**

Arcadia Counseling CENTER

PATIENT'S BILL OF RIGHTS

As a person receiving mental health services, you have the right to:

a) Be treated with dignity and respect.
b) Be informed about ACC rules, treatment procedures, costs, risks, rights and responsibilities.
c) Participate fully in all decisions about treatment or services.
d) Have all your information kept confidential, unless explained otherwise.
e) Request changes in treatment or services.
f) Refuse treatment or service unless ordered by the Court to participate.
g) Not be subjected to verbal, physical, sexual, emotional or financial abuse; harsh or unfair treatment.
h) File a grievance if you are not satisfied with the response to a complaint.
i) Review your record, without exceptions.
j) Exercise all civil and legal rights afforded to citizens of the United
k) Not be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, disability, or marital status.

I have reviewed and understand the abovementioned Consent to Treatment and/or Evaluation and to Use and Disclose Health Information and Bill of Rights, and can request to review the Notice of Privacy Practices, and hereby consent to the evaluation and treatment provided by Arcadia Counseling Center, LLC.

_____ _____
Client Signature/Legal Guardian Signature Date

_____ _____
Arcadia Counseling Center, LLC Signature Date