New Client Form

Full Name (client) _____ Birth date _____

Address _____ Age _____

City, State, Zip _____ Gender: Female ___ Male___

Your Phone #: ( ) _____-_____ ( ) _____-_____

Home – Ok to contact there? Yes / No Work/Cell. – Ok to contact there? Yes / No

Your e-mail:_____

Emergency Contact _____ Phone ( ) _____-_____

Name Relationship to client

Client SSN _____-_____-_____ Relationship Status: Single Married Divorced Separated Dom. Partner Widowed

Parent(s) Name (for minors): _____

_____

Please list other persons living in your household and their relationship/age to you/client:

_____ _____

_____ _____

_____ _____

Medical Health Ins. Plan _____

Primary Care Physician _____ Phone _____

May we contact your PCP to coordinate care? yes _____no_____; Date Contacted_____

Mental Health Ins. Plan _____

Psychiatrist_____

May we contact your Psychiatrist? yes _____no_____; Date Contacted_____

What is your highest level of education? High School _____College _____Graduate School_____

Your Occupation _____

**How did you hear about 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	Effect	Little Effect	Much Effect	Significant	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?

_____

_____

Arcadia Counseling Center (ACC)

FEE AGREEMENT

for Services with

Crystal Contreras MC, LPC

All payment for psychotherapy is due on the same day of service. This provider accepts cash, personal checks and credit/debit cards. Individuals that do not attend therapy with the financially responsible party must bring payment with them or have the responsible party leave a credit card on file. Outstanding balances will not be carried forward unless the client has made a previous arrangement with their therapist.

OUT-OF-POCKET PAYMENT

The initial intake session will be charged at the rate of $145.00. Each 50-minute session thereafter will be charged at the rate of $130.00. Rates to review documentation or to prepare written reports will be charged at $60.00 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. Initial _____

All clients are required to leave a credit card on file to address missed session/late cancellation fees and/or to pay their session fee if that is desired. Clients may request receipts via the form of a "Superbill" for reimbursement or personal purposes at any time.

I, _____, hereby authorize Arcadia Counseling Center, to charge my credit card as payment for my individual, family and/or group sessions on the same day the service is rendered for the amount or balance due and/or for missed/late cancel fees. If I do not wish to pay my session fee with my card kept on file, I understand a card will still be kept on file to be used for any missed/late cancel session fees incurred per the policy outlined in the ACC cancellation policy.

Type of Card: Visa: _____ MasterCard: _____ Amex: _____ Discover: _____

Credit Card Number: _____

Expiration Month & Year: _____

CVV (three digits on back of card)_____

Name of Cardholder: _____

Credit Card Billing Address: _____ (if different than one provided)

Authorized Signature of Cardholder_____

I acknowledge the payment policy described above, and assume full responsibility for all charges. I agree to honor and abide by the terms of payment.

Client Signature: _____ Date_____

Arcadia Counseling Center Cancellation Policy

If you fail to cancel a scheduled appointment within 24 hours of your scheduled session, we cannot use this time for another client. Therefore, you will be billed for the entire cost of your missed appointment. With the client's signature, it is understood by the client that a full session fee of $130.00 (not just the co-pay if you are utilizing insurance) is automatically charged for missed appointments/no shows and cancellations with less than a 24-hour notice.

Thank you for your consideration regarding this important matter.

Client/Guardian Signature: _____ Date: _____

Staff Witness: _____ Date: _____

CONSENT FOR TREATMENT, USE AND DISCLOSURE OF HEALTH INFORMATION AND PATIENT RIGHTS

I, voluntarily apply for evaluation/treatment at Arcadia Counseling Center and understand, consent and agree as follows (to be executed by legally authorized person if patient incapable of giving informed consent):

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.) Information developed as part of the evaluation/treatment and your psychiatric record is confidential but may be released to those parties as required by law, such as (information may be released without my consent) in cases of medical emergency, abuse or neglect, court order, insurance billing claims requirements, and where otherwise legally required. In all other situations a properly executed consent from (which may be withdrawn except to the extent to which it has been acted upon) is required.

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 revisions.

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 Date

_____ _____

Staff Member (witness) Date