Arcadia Counseling CENTER

NEW CLIENT INFORMATION

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? _____

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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?

_____

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FEE AGREEMENT FOR PROFESSIONAL SERVICES

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

OUT-OF-POCKET PAYMENT

_____The initial intake session will be charged at the rate of $165.00. Each 50-minute session thereafter will be charged at the rate of $150.00. Rates to review documentation or to prepare written reports will be charged at $75.00 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: _____**

Payment can be made via use of a Credit/Debit card: □Visa □ MasterCard □ Discover Card □ AMEX

Name on Card:_____ Card #:_____

Billing Address:_____ Expiration: _____/20_____ ; CIV _____

_____ Auth. Signature:_____

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. "No-shows" or "forgotten" appointments will also result in the client being responsible for payment of that session.

****By checking either of the above payment methods, the client agrees to the above cancellation policy****

Arcadia Counseling Center reserves the right to change fees at a later date; however, advanced notice will be given.
ACC can provide you with a receipt for your insurance company, if needed; the fee amount, a diagnosis, our tax ID, and our signature will be included on the receipt. *However, it is **NOT** our responsibility to file claims on your behalf, or to confirm whether your insurance company will reimburse you for our services.* We recommend that you contact your insurance carrier directly to inquire about kinds of services covered, the number of sessions covered, and the turn-around time for reimbursement.

_____ _____
Client/Parent Signature Date

_____ _____
Staff Member (witness) Date

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

I, voluntarily apply for evaluation/treatment at Arcadia Counseling Center LLC 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.

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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