NEW CLIENTS OF ARBOR COUNSELING CENTER

Client Name: ____

Date and Time of Initial Session: _________________________________

- Please complete and sign the attached forms.

- Please have your insurance card ready to be copied for our records.

- If you have an Employee Assistance Program (EAP), please enter your authorization number.

  EAP Authorization Number: ________________________________

- If you are utilizing insurance benefits, many insurers require authorization prior to treatment. Please enter an authorization number if one was given.

  Insurance Authorization Number: ____________________________

- Please have your payment ready prior to the session. Your therapist can accept your cash, check, or credit card. A $50.00 minimum per credit card transaction is required. Checks are to be made payable to: Arbor Counseling Center.

- If you have any questions regarding payment, insurance, or employee assistance programs, please don't hesitate to ask your therapist.

WELCOME TO ARBOR COUNSELING CENTER

Thank you for choosing Arbor Counseling Center as your provider. Please carefully review the following information and provide appropriate signatures.

HIPAA: Arbor Counseling Center follows all federal HIPAA laws. A Notice of Privacy Practices is available upon request.

Confidentiality: We agree to abide by all legal and ethical standards regarding confidentiality. We will not disclose information about you, or even confirm your participation in services, without your written consent. The following are possible exceptions:

- Court Order
- Clear and present danger to self or others
- Suspicion of child abuse
- Information required by insurance companies or EAPs for client reimbursement

Attendance and Costs: A typical counseling session is 45-60 minutes in length. The fee for the initial session is $200.00. Subsequent sessions are $185.00. Fees may vary due to contracted or negotiated rates.

1. If you are utilizing your insurance, we will bill your insurance company directly; however, your insurance policy is a contract between you and your insurance carrier. **You are responsible for all charges not covered by your carrier.** Please be aware that your co-pay is due at each session and that you are responsible for the full session fee if you have not met your deductible.
2. **Arbor Counseling Center is not a Medicare/Medicaid provider.** If you are using a secondary or supplemental insurance and your claim is unpaid, you are responsible for the balance.
3. EAP-approved sessions will be exempt from payment.
4. Payment can be made by cash, check, or credit card. A $50.00 minimum per credit card transaction is required. We ask that you provide a credit/debit card to keep on file. Please let your therapist know if you would like to pay by credit card. We will only utilize your credit card with your permission or if there is an unpaid balance for over 30 days.
5. Additional costs may be incurred for services beyond session fees. These may include writing of reports or appearances outside of the office. These services will be charged at our hourly rate of $185.00. Insurance rarely covers these services.
6. **CANCELLATION POLICY:** Once you agree to an appointment time, that time is reserved between you and your therapist. In the event you cannot keep that appointment, **24 hour notice is required**. If 24 hour notice is not given, a fee equal to your session charge will be assessed.

I have read the above statements; I agree to the aforementioned guidelines and give consent to begin counseling services.

Client's Signature____ Date_______________

Parent's Signature____ Date_______________
(If client is under 18 years old)

CREDIT CARD INFORMATION

I, _________________________, **agree to pay all fees related to services.**

Credit Card MasterCard ______ Visa ______ Discover______

Card# ____

Expiration Date: __________ 3 Digit Code on back of card: _________

Cardholder's Signature________________________________ Date_______________

ARBOR COUNSELING CENTER SOCIAL MEDIA POLICY

Arbor Counseling Center protects your privacy in accordance with the ethical standards of our profession and HIPAA compliancy laws. We ask that you read and agree to our following Social Media Policy.

1. Arbor Counseling Center clinicians are not allowed to engage in any social media communications with clients. This potentially compromises a client's right to privacy. Such sites may include Facebook, Instagram, Linked In, Twitter, etc.

2. Information that is emailed may become a matter of clinical record. We will do everything within our means to protect such information, however we cannot guarantee it. We ask that emails remain limited to basic communication and not include personally sensitive information.

3. Texting back and forth between you and your therapist should remain limited to appointment time related information. This may include appointment reminders, changes, or confirmations.

4. An emergency may prompt you to call your therapist through our telephone system. If your therapist is unable to respond, we will attempt to reach you through our on call therapist. Texting, utilizing a therapist cell phone, or emailing is not an appropriate method to address a life threatening emergency. Clients who are in a life threatening emergency should call 911.

I have read and understand the above stated policy.

____________________________ ________________________

Client Date

ARBOR COUNSELING CENTER   Intake Form

Date: ___________________________

CLIENT INFORMATION:

Social Security #: _______-_______-_______

Client Name: ____ DOB: ___/___/______ Age: ______

Address: ____City:______________________Zip:___________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________
May we text you appointment reminders? Y N At which phone(s) may we leave a message? H ____C____ W_____

E-Mail Address: ____ May we email you practice information? Y N

Marital Status: Married____ Single____ Divorced____ Widowed____ Partnered____

If Married/Partnered, how long: ____________ Spouse's/Partner's name: _________________________________

Name of **GUARDIAN** and relationship if Client is under 18 years old: ____

Guardian Cell Phone: ____________________ Guardian Work Phone: ____________________
May we text you appointment reminders? Y N At which phone(s) may we leave a message? C____ W_____

Other important people for the client:

NAME	*AGE*	*RELATIONSHIP*

BENEFIT INFORMATION:

If you are utilizing an Employee Assistance Program (EAP) benefit, please enter the following:

Employee: _________________________ Date of Birth: _____/_____/__________ Employer: ___________________

EAP Company: _____________________ Number of Sessions: _____ Authorization #: ___________________________

If you are utilizing an Insurance benefit, please enter the following:

Policyholder: _______________________ Date of Birth: _____/_____/__________ Employer: ___________________

Policyholder Address: ____

Name of Insurance Company: ____

Insurance ID Number: _______________________ Insured Group Number: ________________________________

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Arbor Counseling Center to submit claims for benefits for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Signature of Subscriber: ____

What made you choose Arbor Counseling Center? *(√Check* ***all*** *boxes that apply.)*

- ☐ I am a returning client
- ☐ Another Arbor client recommendation
- ☐ Arbor Counseling Center website
- ☐ Other therapist recommendation_____________________
- ☐ School recommendation _____________________
- ☐ Hospital/Doctor recommendation _____________________
- ☐ Church/synagogue/mosque recommendation__________
- ☐ Insurance company
- ☐ Employee Assistance Program
- ☐ Internet_____________________________
- ☐ Other _______________________________

Office Use Only RFV:
Therapist:

ARBOR COUNSELING CENTER
CLIENT INTAKE CHECKLIST

Dear Client: To serve you better and help us make sure we will cover any areas of concern you may have, please circle your answer to each question below. Thank you for your cooperation.

Name: ______________________________ Date: ____________________

Address: ____

Age/Birth Date: ____________________________

1) Do you have any current or history of medical conditions/illnesses? Yes No

   If yes, explain ____

2) Are you on any current medications/treatment? Yes No

   If yes, medication/treatment __________________________________

   Physician name/phone ____

3) Are you having difficulty sleeping? Yes No
4) Have you/others been concerned about your alcohol or drug use? Yes No
5) Do any family members have alcohol or drug problems? Yes No
6) Do you starve yourself or make yourself throw up? Yes No
7) Do you have sexual concerns? Yes No
8) Do you have thoughts about hurting yourself? Yes No
9) Do you have any thoughts about hurting others? Yes No
10) Do you feel you are in danger of being hurt? Yes No
11) Have you moved in the last two years? Yes No
12) Do you find it hard to talk about personal problems with other people? Yes No
13) Do you have problems in your relationships with other people? Yes No
14) Do you prefer not to participate in community or social activities? Yes No
15) Have you changed jobs/schools in the last two years? Yes No
16) Do you hate going to work/school? Yes No
17) Do you have a legal problem? Yes No
18) Are your experiencing financial problems? Yes No
19) Have you lost hope that your problem can be resolved? Yes No
20) Have you lost motivation to work on your problem? Yes No

COORDINATION OF MEDICAL SERVICES

In order to provide the highest quality of care, we ask that you approve or deny permission to communicate with additional providers involved in your healthcare.

Please complete the following:

Client Name _______________________________________ Date of Birth ____________ Gender ____________

__ **I do <u>not</u> give permission** to communicate with my other healthcare providers.

__ **I give permission** to contact the following providers, e.g. primary care, psychiatrists, pediatricians, etc...

1. Name____

   Practice____

   Address____

   Phone____

2. Name____

   Practice____

   Address____

   Phone____

Client's Signature_______________________________________ Date_______________

Parent's Signature_______________________________________ Date_______________
(If client is under 18 years old)

For Therapist Use:

___ New referral by physician (If more than one physician above, please note which is the referring physician.)

___ New referral <u>not</u> by physician

___ Current client

Additional information to include in physician collaboration letter:

____

____

____

Therapist name ________________________________

ARBOR COUNSELING CENTER
CONSENT FOR RELEASE OF INFORMATION

Client Name ______________________________ Date of Birth ____________________

I, ____ hereby authorize Arbor Counseling Center to:

☐ RELEASE TO: ☐ RECEIVE FROM:

Name: ____

Address: ____

Phone #: ______________________________

THE FOLLOWING INFORMATION:

☐ Case Progress ☐ Attendance

☐ Progress Notes ☐ Psychological Reports

☐ Treatment Recommendations ☐ Diagnosis and Diagnostic Impressions

AND/OR ____

FOR THE PURPOSE OF:

☐ Coordination of Services

☐ Treatment Recommendations

☐ Attendance Compliance

AND/OR ____

I understand that my authorization will remain effective from the date of my signature until ________________, and the information will be handled in compliance with all confidentiality laws, and that I may revoke the authorization at any time by written, dated communication.

Client's Signature____Date________________

Parent's Signature____Date________________
(If client is under 18 years old)

Witness ____Date________________