

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 _____

Guardian's Signature _____ Date _____

(If client is under 18 years old)

CREDIT CARD INFORMATION

Check if this is a FSA(flexible spending account) or HSA(health savings account)

I, _____, agree to pay all fees related to services.

Credit Card MasterCard _____ Visa _____ Discover _____ American Express _____

Card# _____ Expiration: _____ Security code: _____

Street Address _____ Zip code _____

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

Guardian's Signature (if client is under 18 years old)

Date

ARBOR COUNSELING CENTER INTAKE FORM

Date: _____

Date of Appointment: _____

CLIENT INFORMATION:

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:

<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>

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 you 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 **not** 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 _____ Email _____

2. Name _____

Practice _____

Address _____

Phone _____ Email _____

Client's Signature _____ Date _____

Guardian'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 not by physician

Current client

Additional information to include in physician collaboration letter:

Therapist name _____

ARBOR COUNSELING CENTER

CONSENT FOR RELEASE OF INFORMATION

I, _____ hereby authorize Arbor Counseling Center
to Release Receive

TO/FROM _____

ADDRESS _____

PHONE # _____

THE FOLLOWING INFORMATION:

- Case Progress Progress Notes Treatment Recommendations Attendance
 Psychological Reports Diagnosis and Diagnostic Impressions

AND/OR _____

FOR THE PURPOSES 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.

Signature of Client

DATE _____

Signature of Guardian (if client is under the age of 18)

DATE _____

Witness

DATE _____