Instructions for Intake Forms

These forms may look daunting at first. Many of these you will simply read and then sign. Most of them are required by health laws and are meant to protect your rights as a client. The first four pages are the most tedious, but the information will help me quickly gain a better understanding of your needs.

You can print the form and fill it out by hand or you can download the PDF to a computer and type in the information in the light-blue highlighted spaces. I have given you options, and I leave the decision up to you. However you do it, please come to the intake appointment with as much as possible completed.

1. **Personal Data Intake Information Form** (pages 1 to 4). Please fill in as much information as possible. Whatever you don't complete we will do at our intake appointment.
2. **Informed Consent.** Please read and sign this page. Print or type in your name next to the signature.
3. **Medical Emergency Release, etc.** Please provide the name of your emergency contact person, their relationship to you, and their phone number. This information would only be used if you experience a medical emergency while in my company. ALSO – there are two other things for you to acknowledge on this page that really have nothing to do with a medical emergency. Electronic mail can be used to communicate with you if you agree in the space provided on this page. Please note your agreement and include your email address. ALSO – in the final space on this page, please acknowledge that we will not establish a relationship with you via social media. Your initials will suffice.
4. **Professional Disclosure**. This is a required one page overview of my professional experience and policies. Please sign and date.
5. **Notice of Privacy Practices**. This 3 page required document describes how some of your health information is obtained and how it might be shared.
6. **Notice of Privacy Practices – Acknowledgment of Receipt**. Please sign and date this one page which says you received and read the 3 previous pages.
7. **Health Advisement**. This page provides some pertinent information, which may or may not be relevant to you. Please print your name and sign and date.
8. **Financial Agreement**. This page informs you about fees, payments, insurance, and other relevant information. Please sign and date indicating you understand how this works.
9. **Authorization for Use and/or Disclosure of Protected Health Information**. This form will need to be completed if you want me to provide information about you to a third party. Do not fill this out if not needed.

1. Personal Data Intake Information Form

Today's Date: _____

Demographics

Client's First Name: _____ MI: _____ Last Name: _____

Client prefers to be called: _____

DOB: _____ Age: _____ Gender: ☐Male ☐Female

Social Security Number: _____-_____-_____

Name of person completing this form: _____ Relationship to Client: _____

Client's Primary Address: _____ How long have you lived at this address? _____

_____

_____

Client's Phone Numbers: (Check YES or NO if I can call and identify myself or leave messages on each phone)

Home: _____ Call and identify: ☐YES ☐NO Leave message: ☐YES ☐NO

Cell: _____ Call and identify: ☐YES ☐NO Leave message: ☐YES ☐NO
Text Reminders: ☐YES ☐NO

Work: _____ Call and identify: ☐YES ☐NO Leave message: ☐YES ☐NO

How would you prefer appointment reminders? ☐ Phone call ☐ Text Message ☐ Email ☐ None

Current Marital Status:
☐ Single – Never Married
☐ Married
☐ Separated
☐ Living together, but not legally married
☐ Divorced
☐ Widowed
☐ Minor Child
Number of Marriages: _____

Race
☐ White
☐ Black
☐ Native American
☐ Hispanic
☐ Asian
☐ Pacific Islander
☐ Other _____
☐ More than one race

Highest Education Completed
☐ Grade _____
☐ Associate Degree
☐ Certificate Program
☐ Bachelors Degree
☐ Masters Degree
☐ Professional Degree (JD, MD)
☐ PhD

Military History

Are you a military veteran? ☐ Yes ☐ No Are you currently on active duty in the military? ☐ Yes ☐ No

If you have military history, what branch? _____ Have you ever been deployed? ☐ Yes ☐ No

Legal

Have you ever been arrested? ☐Yes ☐No If yes, what charges? _____

Have you ever been convicted? ☐Yes ☐No If yes, what charges? _____

Do you have any current legal concerns? _____

Educational Experience:

Tell me about your school experiences. How were your grades; were you bullied; did you participate in extracurricular activities or have any major disruptions in your school experiences, such as moves?

_____

_____

_____

_____

Current level of employment:

☐ Unemployed ☐ Part-time: Paid work less than 30 hrs/wk ☐ Full-time: Paid work more than 30 hrs/wk
☐ Homemaker ☐ Day laborer: No consistent work ☐ Retired from active employment
☐ Child under 15 ☐ Full-time student ☐ Disabled and unable to work
☐ Other (please indicate): _____

How long have you been at your current job? _____

Do you have any employment concerns? _____

Do you have financial concerns? _____

Who lives with you?

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

How would you describe your relationships with the people you live with? Who do you get along with the best and who do you have the most conflict with? _____

_____

_____

Do you have any other immediate family who does not live with you? (If yes, list below)

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Are you adopted? ☐ Yes ☐ No

Where were you raised? _____

Do any of your family members have any diagnosed mental health concerns? (Relationship and diagnosis)

_____

_____

_____

Who referred you to Addiction Recovery Counseling, LLC?

☐ Self	☐ Police/Law Enforcement	☐ Another counselor
☐ Family/Friend	☐ Court/Judge	☐ Hospital
☐ School	☐ Probation Officer	☐ Clergy
☐ Employer	☐ Inpatient SA/MA Facility	☐ Attorney
☐ EAP	☐ Doctor/Medical Professional	☐ Other _____

Medical

Current Medical Conditions:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Seizures ☐ Tuberculosis ☐ Activity Restrictions

☐ Dietary Restrictions ☐ Allergies_____ ☐ Infections Disease _____

☐ Other _____

Past Health Problems: _____

Date of Last Physician Visit: _____

Name of Current Physician: _____

Current Medications	Dose	Prescribed For?	Side Effects?	Helpful?

SUBSTANCE ABUSE SCREENING SELF-REPORT

Have you used or are you currently using:		**Please check if current**
Alcohol	Frequency/Amount: _____	☐
Marijuana	Frequency/Amount: _____	☐
Cocaine	Frequency/Amount: _____	☐
Meth	Frequency/Amount: _____	☐
Pain Pills	Frequency/Amount: _____	☐
Heroin	Frequency/Amount: _____	☐
Sleeping Pills	Frequency/Amount: _____	☐
Tranquilizers	Frequency/Amount: _____	☐
Nicotine	Frequency/Amount: _____	☐
Caffeine	Frequency/Amount: _____	☐
Diet Pills	Frequency/Amount: _____	☐
Spice	Frequency/Amount: _____	☐
Bath Salts	Frequency/Amount: _____	☐
LSD/PCP	Frequency/Amount: _____	☐
Ecstasy/Molly	Frequency/Amount: _____	☐
_____ (other)	Frequency/Amount: _____	☐

If you checked yes to any of the above answer the following:	**Please check if yes**
Have other people said you have a problem with drugs and/or alcohol?	☐
Has your use of drugs and/or alcohol interfered with school, work or social functioning?	☐
Have you ever been arrested for behavior that occurred under the influence of drugs and/or alcohol? (e.g. disorderly conduct, DUI, MIP, other crimes?)	☐
Have you ever tried to cut back on your use of drugs and/or alcohol and been unsuccessful?	☐
Have you noticed that it takes more of your drug or alcohol to have the same effect?	☐
When you stop using your drug and/or alcohol do you have any side effects?	☐
Do you focus a lot on getting drugs and/or alcohol?	☐
Are you preoccupied with your next use or obtaining the drug?	☐
Have you stopped doing activities because you were using drugs and/or alcohol?	☐

Previous Treatment (when, where, outcomes): _____

_____

_____

2. Informed Consent

The purpose of this agreement is to set forth the basic guidelines concerning your services at Addiction Recovery Counseling, LLC (ARC). Therapy is a process that takes place between a client and the therapist. There are many different treatment approaches that may be used to help treat the problems that you want to address. Therapy requires an active effort on your part. In order for therapy to be successful, one important part is you working on the things discussed in session both during the session and between sessions. Therapy can have risks and benefits. There are no guarantees of what you will experience. Counseling is voluntary and you can end your involvement any time for any reason. The first couple of sessions will involve evaluation of your needs. After that, we will work to develop goals and a treatment plan. You have the right to accept or reject any suggested intervention. You have the right to have your counselor make reasonable decisions about your care. Treatment methods, benefits, and possible alternatives will be explained to you, as well as the possible consequences of not receiving treatment. The risks and benefits will be explained to you. You have the right to evaluate all this information, along with your own opinions of whether or not you feel comfortable working with me.

In addition to this there are a few other things that are important to note:

- Fees and billing procedures for all services will be explained to you in advance.
- You will not be recorded or videotaped without your written consent or knowledge.
- Any testing, reports, and/or referral procedures will be explained to you.
- Treatment information is considered confidential within certain state and federal limitations. Consent for release of information must be both provided and withdrawn in writing.
- If you are using a credit card for payment, you authorize ARC to store and charge for services and no show fees, as applicable.
- You have the right to refuse electronic communication and to providing emergency medical contacts. Be aware that you are welcome to communicate via electronic means, but understand that there are risks involved in using the communication. Also note that any emails are considered part of your legal record.
- You are entitled to receive a copy of your records, or a prepared summary. Because these are professional records, they can be misinterpreted and be upsetting to untrained readers. If you wish to see your records, I recommend you review them with me.
- If you are under 18, please be aware that the law may provide your parents the right to examine your treatment records.
- If you are unable to reach me in an emergency, you or someone you trust should call the local emergency room, your medical doctor, or 911. If I am unavailable for an extended period of time, I will provide you will the name of a colleague or agency to contact, if necessary. If you do contact me with an emergency and I assess you may be at risk to harm self or others, I may contact your Primary Care Physician, your emergency contact, or emergency personnel to advocate for your care and safety.

I have been given the opportunity to question the above information about consents and releases of information. I voluntarily agree to treatment at Addiction Recovery Counseling, LLC, with Julie Diggins, LCDC. Your signature below indicates that you have read this information and agree to abide by its terms during our professional relationship.

_____

Client Signature | Client Printed Name | Date

_____

Parent/Guardian Signature | Parent/Guardian Printed Name | Date

_____

Clinician Signature | Clinician Printed Name | Date

3. Medical Emergency Release

A medical emergency is a situation that poses an immediate threat to the health of an individual (it does not have to be the client) and requires immediate medical intervention. Without prior written consent, ARC is not authorized to notify family or significant others, unless there is specific authorization from the client consenting to this release of information. When using or disclosing protected health information Addiction Recovery Counseling, LLC will make reasonable efforts to limit information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. In case of a medical emergency, I give written consent to Addiction Recovery Counseling, LLC staff to contact:

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

Informed Consent of Electronic Messaging

Unsecured Electronic Messaging may be used with clients for communicating PHI that has minimal privacy related consequences, such as appointment reminders or receipts for credit card payment. Addiction Recovery Counseling, LLC can respond to electronic queries, but is not obligated to respond electronically and such responses must be conducted with care. To communicate with you electronically, you must provide your consent, recognizing that email and text messages, for example, are not a secure form of communication. There is some risk that any protected health information that may be contained in such an email may be disclosed to, or intercepted by unauthorized third parties. ARC will use the minimum necessary amount of protected health information in electronic communication. In addition to this informed consent, any correspondence between a client and ARC staff will require the clinician to respond to your request within the parameters of the information provided below.

I acknowledge that I understand the risks associated with electronic messaging and consent to its use, as minimally necessary. The email address I give consent to use in electronic communication is below:

_____

Social Media

Social media is a huge part of our culture. However, due to ethical guidelines and rules, ARC is unable to connect with you through individual personal profiles. This has nothing to do with anything about you personally, but rather it is because of ethical standards that must be followed. Any attempts to friend ARC personnel on their personal social media profiles will be declined based on this.

Client Initials_____ Date _____

4. **Professional Disclosure**

Julie Diggins, MA, LCDC #13313, LSSP, NCSP
BACHELOR OF SCIENCE IN PSYCHOLOGY, UNIVERSITY OF HOUSTON AT CLEAR LAKE
MASTERS OF ARTS IN PSYCHOLOGY FROM UNIVERSITY OF HOUSTON AT CLEAR LAKE

My specialty is one-on-one addiction counseling, which stems from over 25 years of counseling experience and many years of addiction recovery. While millions of people seek and find addiction recovery through group experiences, you may not be ready to sit in a room with other addicts and alcoholics and talk about your problems. As your counselor I will treat you with dignity and respect and I will strive to offer you the highest quality of service to help you with your addiction issues. During the course of treatment I will take into consideration what addiction you are suffering from, my training, and my assessment of what will benefit you most. I am likely to draw from several psychological approaches, such as cognitive-behavioral and motivational interviewing. In the event that a more intensive level of care or treatment outside my scope of competence is warranted, I may provide you with a referral to another professional for those services. If referred for additional services, you will be responsible for payment for those services. You also have the right to accept or reject my recommendations. In addition to my LCDC practice, I have 25 years of experience as a Specialist in School Psychology providing psychological services to hundreds of children and their families.

As a Licensed Chemical Dependency Counselor, I follow the rules and regulations of the Licensing and Certification Unit of the Department of Texas State Health and Human Services, and the Texas Occupations Code, Chapter 504. These include but are not limited to rules governing standards of confidentiality, dual relationships, and the prohibition of sexual intimacy between counselors and clients. Sexual intimacy with a client is never appropriate.

Regarding standards of confidentiality, all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client or parent's) written permission, except when required by law. I am required to report any known or suspected child or elder abuse or neglect, and to take action to ensure safety if a client presents danger to self or others. As an LCDC, client files are owned by and payment for counseling services are made to Addiction Recovery Counseling. For educational and professional purposes, I consult regularly with other professionals regarding clients in order to ensure quality of my service; however, a client's name or other identifying information in never mentioned. Please review the HIPAA Notice for more information.

I read and understand the information above.

_____ _____ _____

Client Signature Date Clinician Signature

5. Notice of Privacy Practices

This notice describes how information about you that is obtained during the course of treatment may be used and disclosed and how you can obtain access to this information.

Health information which Addiction Recovery Counseling, LLC (ARC) receives about you, while in this office, relating to your past, present or future health treatment, or payment for healthcare services, is "protected health information" under the Federal law known as the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR part 160 & 164. The confidentiality of alcohol and drug abuse records maintained in our program is protected by another Federal law commonly referred to as the Alcohol and Other Drug Confidentiality Law, 42 CFR part 2. Generally, staff at ARC may not say to a person outside the organization that you are receiving services, disclose any information identifying you as an alcohol or drug abuser, or use or disclose any other protected health information, except in limited circumstances, as permitted by Federal law. Any pertinent state law that is more protective or stringent than either of the two Federal laws further protects your health information.

Use and disclosures that may be made of your health information:

1. **Internal communications:** Your protected health information will be used within ARC, which is between and among staff who have the need for the information in connection with our duty to diagnose, treat or refer you for other more appropriate treatments. This means that your protected health information may be shared between or among staff members for treatment, payment or other care related operational purposes. For example: The program may share your protected health information in a billing effort to receive payment for health care services provided to you.
2. **Qualified Service Organizations and/or Business Associates:** Some or all of your protected health information may be subject to disclosure through contracts for services with qualified service organizations and/or business associates, outside of the program, that assist ARC in providing care. Examples of qualified service organizations and/or business associates include billing companies, data processing companies or companies that provide administrative or specialty services. To protect your health information, we require these qualified service organizations and/or business associates to follow the same standards held by this program through terms detailed in a written agreement.
3. **Medical Emergencies:** Your health information may be disclosed to medical personnel in a medical emergency, when there is an imminent and immediate threat or danger to the health and safety of an individual, and when immediate medical intervention is required.
4. **Auditors and Evaluators:** This program may disclose protected health information to regulatory agencies, third-party payers, and other review organizations that monitor our programs to ensure that the program is complying with regulatory mandates.
5. **Authorizing Court Order:** This program may disclose your protected health information in accordance with an authorizing court order. This is a unique kind of court order in which certain application procedures have been taken to protect your identity, and in which the court makes certain specific determination, as outlined in the Federal regulations, that limits the scope of the disclosure.
6. **Crime on Premises or Against Program Personnel:** ARC may disclose a limited amount of protected health information to law enforcement when a patient commits or threatens to commit a crime on the program premises or against ARC staff.
7. **Reporting Suspected Child or Elder Abuse or Neglect:** This program may report suspected child or elder abuse and neglect as mandated by state law.
8. **As Required by Law:** This program will disclose protected health information as required by state law in a manner otherwise permitted by federal privacy and confidentiality regulations.

9. **Appointment Reminders:** This program reserves the right to contact you, in a manner permitted by law, with appointment reminders or information about treatment alternatives and other health related benefits that might be appropriate to you.
10. **Payment:** Your protected health information will be used and disclosed in order to obtain payment for treatment and services you receive. A bill may be sent to you, an insurance company, or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used, and any other information that may be reasonably required for payment purposes. Your protected health information may also be used or disclosed in other payment related activities, such as claims management activities. We may tell your insurance company about a test or treatment you are going to receive in order to receive prior approval or to determine whether your insurance plan will cover the treatment.
11. **Other Uses and Disclosure of Protected Health Information:** Other uses and disclosures of protected health information not covered by this notice will be made only with your written authorization or that of your legal representative. If you or your legal representative authorizes us to use or disclose protected health information about you, you or your legal representative may revoke that authorization, at any time, except to the extent that we have already taken action relying on that authorization.

Your rights regarding protected health information we maintain about you:

1. **Right to Inspect and Copy:** In most cases, you have the right to inspect and obtain a copy of the protected health information that we maintain about you. To inspect and copy your protected health information, you must submit a request, in writing, to this office. In order to receive a copy of your protected health information, you may be charged a fee for the photocopying, mailing or other costs associated with your request. In some very limited circumstances we may, as authorized by law, deny your request to inspect and obtain a copy of your protected health information. You will be notified of a denial of any part or parts of your request. Some denials, by law, are reviewable, and you will be notified regarding the procedures for invoking a right to have a denial reviewed. Other denials, however, as set forth in the law, are not reviewable. Each request will be reviewed individually and a response will be provided to you in accordance with the law.
2. **Right to Amend Your Protected Health Information:** If you believe that your protected health information is incorrect, or that an important part of it is missing, you have the right to ask us to amend your protected health information while it is kept by or for us. You must provide your request and your reason for the request in writing and submit it to this office. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend protected health information that we believe:
    a. Is accurate and complete;
    b. Was not created by us, unless the person or entity that created the protected health information is no longer available to make the amendment;
    c. Is not part of the protected health information kept by or for us; or
    d. Is not part of the protected health information that you would be permitted to inspect and copy.

    If your right to amend is denied, we will notify you of the denial and provide you with instructions on how you may exercise your right to submit a written statement disagreeing with the denial, and/or how you may request that your request to amend and a copy of the denial letter be kept together with the protected health information at issue, and disclosed together with any further disclosures of the protected health information at issue.
3. **Right to Accounting of Disclosures:** You have a right to request an accounting or list of the disclosures that we have made of protected health information about you. This list will not include certain disclosures as set forth in the HIPAA regulations, including those made for treatment, payment or other care related operations within our program. To request this list, you must submit your request in writing to this office. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for

responding to additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. **Right to Request Restrictions:** You have the right to request a restriction or limitation on protected health information we are permitted to use or disclose about you for treatment, payment or other care related operations within our program. While we will consider your request, we are not required to agree with it. If we do agree to it, we will comply with your request, except in emergency situations where your protected health information is needed to provide you with emergency treatment. We will not agree to restrictions on uses or disclosures that are legally required, or those which are legally permitted and which we reasonably believe to be in the best interest of your mental health.
5. **Right to Request Confidential Communication:** You have the right to request that we communicate with you about protected health information in a certain manner or at a certain location. For example, you can ask that we only contact you at home, or by mail. To request confidential communications, you must make your request in writing to this office, and specify how or where you wish to be contacted. We will accommodate all reasonable requests.
6. **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with this office or with the Texas Department of State Health Services. To file a complaint with this office please contact Julie Diggins, Owner, Nasa Parkway, Suite 220H. You will not be penalized or otherwise retaliated against for filing a complaint. If you have questions about this please contact us as 281-960-9194.

Our Responsibilities

Addiction Recovery Counseling, LLC is required to:

1. Maintain the privacy of your protected health information.
2. Provide you with this notice of our legal duties and privacy practices with respect to your protected health information.
3. Abide by the terms of this notice while it is in effect.

6. Notice of Privacy Practices

Acknowledgement of Receipt

By signing this form you acknowledge receipt of the Notice of Privacy Practices of Addiction Recovery Counseling, LLC. We encourage you to read it in full. If you have any additional questions about our Notice of Privacy Practices, please contact:

Julie Diggins, Owner
1120 Nasa Parkway, Ste. 220H, Houston, TX 77058-3310

I _____ acknowledge receipt of the Notice of Privacy Practices of Addiction
(print client name)

Recovery Counseling, LLC.

Signature: _____

Date:_____

Parent/Guardian Signature: _____ Date: _____

_____

Office Use – Inability to Obtain Acknowledgement

If individual did receive the notice of Privacy Practices, but did not sign this acknowledgement of receipt, state
efforts and the reason why (refused, unable, left too soon, other reason):

If the individual did NOT receive the Notice of Privacy Practices, explain why (emergency treatment, patient
declined receipt, other):

7. Health Advisement

The incidence of Tuberculosis (TB), Hepatitis, Sexually Transmitted Diseases (STD) and HIV has increased among individuals in specific risk categories, including alcoholics, drug-dependent individuals and those who have been jailed or hospitalized. Testing is **optional and voluntary**, but it is in your best interest to be tested for Tuberculosis, Hepatitis, STDs and HIV, if you think you may be at risk. A simple screen is all that is required.

If you don't have medical insurance you can get an appointment for a screening test for TB, HIV, STDs, and a vaccine for Hepatitis A/B at your local public health office: Texas Department of State Health Services (713) 212-6800

Testing for STDs can also be arranged through your physician or one of many testing clinics throughout the Houston/Galveston area.

I, _____, have read (or had someone read to me) and understand the above information.

_____ _____

Client Signature Date

8. **Financial Agreement**

Thank you for allowing Addiction Recovery Counseling, LLC (ARC) to serve you. The following information explains your responsibilities when receiving services.

Fees

ARC accepts some insurances, cash, personal checks, and soon we will accept Visa or MasterCard. Every client begins with an intake appointment, which lasts about two hours. The fee for this appointment is $150. If you need a written substance abuse evaluation, the fee is $200, which covers the time it takes to write a report. It may take a few days for me to get that to you. The customary fee for a counseling session is $90-$110. There is some flexibility regarding this amount and we should discuss this prior to beginning our regular sessions. At the bottom of this page, we will note what we have agreed upon and you will sign that you understand the financial agreement.

Payment

If you are using your health insurance, you are expected to pay your co-pay at each appointment. If this is a problem, let's discuss it. Any remaining payments due will be billed to you at the end of the month. Prompt payment of this amount is expected. Payment for substance use evaluations and for all private pay clients is due at the time of service. As a last resort, debt collection services will be utilized to pursue the collection of fees. Before accounts are turned over to collections, clients will be informed by mail. Accounts are considered delinquent when a client has failed to make payments or payment arrangements for more than 60 days.

Health Insurance

If ARC accepts your health insurance ARC will bill that insurance, with your approval. If your health insurance requires pre-authorization for services, it is your responsibility to coordinate this with your insurance company. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. I will fill out forms and provide you with whatever assistance I can in helping you to receive the benefits to which you are entitled; however ultimately, you (not your insurance company) are responsible for the full payment of fees. **It is very important you find out exactly what services your insurance policy covers so that you are not surprised with unexpected bills.**

Missed Appointments

At ARC we recognize that sometimes life happens and you are unable to make an appointment. However, if it becomes a repeated problem that you are missing appointments without a 24-hour notice, you will be charged a $25.00 no-show fee. This is a standard flat fee and will not be billed to your insurance company.

Claims Processing

I authorize the release of information necessary to process insurance claims (including private carriers and Medicaid) and authorize direct payment of benefits to Addiction Recovery Counseling, LLC. If payment is made directly to me, I hereby agree to promptly remit such payment to Addiction Recovery Counseling. I understand that insurance is a contract between me, my employer and/or the insurance company. Addiction Recovery Counseling is not a party to the contract with your insurance company. I understand that not all services are a covered benefit in all insurance contracts and that I will be responsible for payment should any services not be covered by my insurance.

Authorization for Billing

I acknowledge that I have read and understand the financial agreement and my responsibilities for payment and agree to abide by all of its terms and conditions.

For ARC services you will be charged $_____ for the intake appointment and $_____ per session.

_____ _____

Client/Guardian Signature Date

9. Addiction Recovery Counseling, LLC

Authorization for Use and/or Disclosure of Protected Health Information

I, _____, born on _____ and living at _____

_____ hereby authorize Addiction Recovery Counseling, LLC to exchange the following protected health information with: _____.

The following information may be disclosed (please initial all that apply):

_____ Diagnosis	_____ Results of Psychiatric Testing	_____ Reason for Termination
_____ Substance Use	_____ Number of kept/un-kept appointments	_____ Medications
_____ Progress Notes	_____ Bio-psychosocial Assessment	_____ Other: _____
_____ Recommendations	_____ Drug and Alcohol Evaluation	_____
_____ Treatment Plan	_____ Communicable Disease Information	

This information will be used for the following purpose: _____

_____ I understand and give permission for this information to be shared via fax, e-mail, telephone or documents sent by mail and am willing to assume the associated risks.

This authorization will expire as noted below:
_____ At the end of 60 days
_____ One year from today (maximum time)
_____ At the following event/date: _____
_____ At the termination of my treatment

_____ I understand that I may revoke this authorization by completing the revocation section below. However, I understand that if revoke this authorization, it will not have any effect on actions already taken by Addiction Recovery Counseling in reliance on this authorization.

I understand that my records are protected by federal and state laws and cannot be disclosed without my written permission, except as noted in Addiction Recovery Counseling, LLC's Notice of Privacy Policies. I understand that this release also includes any reference to drug or alcohol treatment, as protected by federal law.

_____

(Signature of Client or Representative) (Date of Signature) (Witness Signature)

_____

(Printed Name, if Client's Representative) (Description of Representative's Authority to Act for the Client, ie relationship)

Revocation: I wish to revoke this authorization: _____ _____
(Signature of Client or Representative) (Date)

Person witnessing the revocation: _____ _____
(Date)

NOTE: The receiving individual or organization understands that it IS NOT TO RE-RELEASE any of the confidential information received. Once the information is used and/or disclosed by Addiction Recovery Counseling, LLC, it is no longer protected by the federal privacy regulations and may be subject to re-disclosure by the recipient.