

**ARKO COUNSELING CENTER**

*Specializing in individual enrichment*

Arko Counseling Center, PLLC

**DOES NOT PROCESS:**

**DISABILITY, FMLA, COURT  
RELATED, OR LICENSURE  
REVOCAATION  
PAPERWORK**

**Marlyn Arko, LPC**

**ARKO COUNSELING CENTER  
INITIAL INFORMATION FORM**

Date \_\_\_\_\_ Marital Status \_\_\_\_\_ Prior client: \_\_\_ Yes \_\_\_ No

Client's First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(Cell) \_\_\_\_\_ May we leave a message? Yes \_\_\_ No \_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_ F \_\_\_ M

Person Responsible for Payment \_\_\_\_\_

Signature of Person Responsible for Payment \_\_\_\_\_ (Must sign for services)

***Emergency Information: In case of emergency, contact:***

Name (1) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other Physicians \_\_\_\_\_ Phone \_\_\_\_\_

Current Medications \_\_\_\_\_

Allergies \_\_\_\_\_

***Employment Information (If client is a child, use parent's employment)***

Client: Place \_\_\_\_\_ Phone \_\_\_\_\_

***Insurance Information***

**Primary Insurance:** \_\_\_\_\_  
Contract/ID# \_\_\_\_\_  
Group/Acct# \_\_\_\_\_

**EAP Provider:** \_\_\_\_\_  
**Phone No.:** \_\_\_\_\_  
**Authorization #** \_\_\_\_\_

Subscriber \_\_\_\_\_  
Subscriber Date of Birth \_\_\_\_\_  
Client's relationship to Subscriber: \_\_\_\_\_

No. session authorized \_\_\_\_\_  
Date of Expiration \_\_\_\_\_

How did you hear of our clinic (or from whom)? \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

**ARKO COUNSELING CENTER**  
**Consent to Treatment and Recipient's Rights**

I, \_\_\_\_\_, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at ARKO COUNSELING CENTER, hereby referred to as the Center. Further, I consent to have treatment provided by a counselor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

**Recipient's Rights:** I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content.

**Non-Voluntary Discharge from Treatment:** A client may be terminated from the Center non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to re-apply for services at a later date.

**Client Notice of Confidentiality:** The confidentiality of patient records maintained by the Center is protected by Federal and/or State law and regulations. Generally, the Center may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information.

My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the stated policies and agreements with ARKO COUNSELING CENTER.

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Date**

**ARKO COUNSELING CENTER**  
**Insurance Payment Contract for Services**

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Bill to: Person responsible for payment of account: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**Federal Truth in Lending Disclosure Statement for Professional Services**

**Part One Fees for Professional Services**

I (we) agree to pay Arko Counseling Center/Marlyn Arko, LPC, hereafter referred to as the clinic, a rate of \$125.00 per clinical unit (defined as 45–50 minutes for individual counseling). *If I/we have insurance or EAP, the contracted rates apply instead.* A fee of **\$50.00** is charged for missed appointments or cancellations with less than 24-hour notice. If you have EAP, one EAP will be deducted for each No Show or Late Cancellation.

**Part Two Clients with Insurance (Deductible and Co-payment Agreement)**

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

**Insurance Benefits**

**NAME OF INSURANCE COMPANY:** \_\_\_\_\_

**AUTHORIZATION NUMBER FOR THESE SESSIONS(if not EAP):** \_\_\_\_\_

**NUMBER OF VISITS AUTHORIZED:** \_\_\_\_\_

**COPAY AMOUNT:** \_\_\_\_\_

**NUMBER OF SESSIONS AUTHORIZED:** \_\_\_\_\_

**LIMIT OF SESSIONS PER YEAR:** \_\_\_\_\_

**DO YOU HAVE A DEDUCTIBLE: YES \_\_\_ NO \_\_\_ IS DEDUCTIBLE MET? YES \_\_\_ NO \_\_\_**

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company. Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

**Part Three All Clients**

Payments, co-payments, and deductible amounts are due at the time of service.

I HEREBY CERTIFY that I have read and agree to the conditions of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: \_\_\_\_\_ Date: \_\_\_\_\_

**Release of Information Authorization to Third Party for Billing Purposes**

I (we) authorize Arko Counseling Center/Marlyn Arko, LPC to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Arko Counseling Center/Marlyn Arko, LPC.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account/Receiving services: \_\_\_\_\_ Date: \_\_\_\_\_

# ARKO COUNSELING CENTER

*Specializing in individual enrichment*

Arko Counseling Center, PLLC utilizes Medical Ancillary Services for insurance and client billing. If you should have unpaid financial obligations to Arko Counseling Center for any service provided by myself or my staff such as late cancellation charges or charges for no shows for scheduled appointments, Medical Ancillary will bill you by mail or contact you by phone and/or email to collect the amount owed.

Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**I AGREE TO EMAIL STATEMENTS:**

\_\_\_\_\_  
Signature

***I AGREE TO EMAIL APPOINTMENT REMINDERS:***

\_\_\_\_\_  
Signature

***I AGREE TO PHONE CALL REMINDERS:***

\_\_\_\_\_  
Signature

You may opt-out from email statements and/or email appointment reminders at any time by written notice.

MARLYN ARKO, LPC

**\*\*PLEASE VERIFY YOUR APPOINTMENTS AND DO NOT DEPEND ENTIRELY ON THE COMPUTERIZED E-MAIL OR PHONE CALL REMINDERS**

## **ARKO COUNSELING CENTER**

### **Privacy of Information Policies**

**This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.**

Effective 4-14-03

#### **Our Legal Duties**

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

#### **Use of Information**

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

#### **Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Public Safety**

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

**Abuse**

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

**Prenatal Exposure to Controlled Substances**

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**In the Event of a Client's Death**

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

**Professional Misconduct**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

**Judicial or Administrative Proceedings**

Health care professionals are required to release records of clients when a court order has been placed.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

**Other Provisions**

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which

may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

### **Electronic Communication**

**E-mail and text communication is not a secure medium for communication and confidentiality is not guaranteed.**

### **Your Rights**

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is \$5.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.



You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

**Complaints**

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner.

**Notice regarding electronic transmissions:**

**Electronic transmission is not a secure medium for communication. Confidentiality is not guaranteed when using texts or e-mails. This office will continue to utilize the utmost care to maintain client privacy and confidentiality.**

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Direct all correspondence to: Arko Counseling Center, Attn: Marlyn Arko, LPC, 10049 E. Dynamite Boulevard, Suite D-135, Scottsdale, AZ 85262.

**I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.**

Client's name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_

Signed by: \_\_client \_\_guardian \_\_personal representative

**ARKO COUNSELING CENTER**  
**Specializing in Individual Enrichment**

**POLICY AS OF 1/1/2009**

Updated 1/1/2012, 5/1/17

NO SHOWS AND CANCELLATIONS with LESS THAN 24 HOURS NOTICE WILL BE CHARGED **\$50.00 PER SESSION.**

***If you have EAP, one EAP session will be deducted for each No Show or Late Cancellation.***

TYPICAL SESSIONS ARE SCHEDULED FOR 50 MINUTES.

Two consecutive **No shows** and/or **cancellations with less than 24 hours notice** will be referred to insurance company.

**BILLING**

Arko Counseling Center is utilizing Medical Ancillary Services for all billing. If you have any questions regarding costs incurred at our office, please e-mail [MHSAbilling@gmail.com](mailto:MHSAbilling@gmail.com) or fax inquiries to 480-304-3047.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**ARKO COUNSELING CENTER**  
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**CLIENT COPY**

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*Marlyn Arko, LPC*