The Arete Center

Excellence in Behavioral Health

CLIENT INFORMATION

Patient Name: _____Date of Birth:: _____

Preferred Name: _____ Preferred Pronouns: _____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ ☐ Arete can leave messages on this line

Cell Phone: _____ ☐ Arete can leave messages / texts on this line

Email Address:_____ ☐ Arete can contact me at this email

Referred by:_____ Gender Identity: _____ Marital Status:_____

GUARDIAN CONTACT INFORMATION (MINOR PATIENTS ONLY)

Parent 1 (if under 18): _____

Phone:_____ ☐ Arete can leave messages on this line

Email:_____ ☐ Arete can contact me at this email

Address (if different from patient): ☐ Party responsible for payment

_____

Parent 2 (if under 18): _____

Phone:_____ ☐ Arete can leave messages on this line

Email:_____ ☐ Arete can contact me at this email

Address (if different from patient): ☐ Party responsible for payment

_____

OTHER CONTACTS:

Emergency Contact: _____

Phone: _____ Relation:_____

Primary Care Provider (provider/practice name):_____

PCP phone: (____)_____ Fax: (____)_____

Current Therapist/Counselor:_____Therapist's Phone:_____

Any Other Provider (provider/practice name):_____

Phone: (____)_____ Fax: (____)_____

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THERAPEUTIC GOALS

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

What are your treatment goals?

1._____

2._____

3._____

Do you have prior testing, diagnostics or diagnosis that would be useful for your clinician to know? Please provide any documentation to your provider prior to your first appointment.

Test / Diagnosis	Clinician	Year
Test / Diagnosis	Clinician	Year

CURRENT SYMPTOMS CHECKLIST:

( ) Depressed or sad mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Low Self-Esteem
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Worthlessness
( ) Low Motivation
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Obsessions
( ) Compulsive Behavior
( ) Body image concerns
( ) other:_____

FAMILY PSYCHIATRIC HISTORY

	You	Family	Which Family Member?
Bipolar Disorder	( )	( )	_____
Depression	( )	( )	_____
Anxiety	( )	( )	_____
Suicide attempts	( )	( )	_____
Schizophrenia	( )	( )	_____
Post-Traumatic Stress Disorder	( )	( )	_____
Obsessive-Compulsive Disorder	( )	( )	_____
Eating Disorder	( )	( )	_____
Alcohol Abuse	( )	( )	_____
Other Substance Abuse	( )	( )	_____
ADHD	( )	( )	_____
Psychiatric Hospitalization	( )	( )	_____
Other: _____	( )	( )	_____

SUBSTANCE USE AND ADDICTION HISTORY:

Current Use (Please circle): Methamphetamines, Cocaine/crack, Speed, Heroin/opioids, Ecstasy, Benzodiazepines, Marijuana, Alcohol, Nicotin, Behavioral Addiction (gambling, compulsive behaviors, internet, sexual), LSD, Mushrooms, DMT

Past Use (Please circle): Methamphetamines, Cocaine/crack, Speed, Heroin/opioids, Ecstasy, Benzodiazepines, Marijuana, Alcohol, Nicotine, Behavioral Addiction (gambling, compulsive behaviors, internet, sexual), LSD, Mushrooms, DMT

Please list any medications you have been prescribed for psychiatric disorders. (please use the back of this sheet if needed)

Medication	Prescribed For	Year
Medication	Prescribed For	Year
Medication	Prescribed For	Year

MEDICAL HISTORY

ALLERGIES: (please list)

_____

_____

CURRENT MEDICATIONS / SUPPLEMENTS: (please use the back of this sheet if needed)

_____

Name | Dosage | Frequency

_____

Name | Dosage | Frequency

_____

Name | Dosage | Frequency

PERSONAL AND FAMILY MEDICAL HISTORY:

	You	Family	Which Family Member?
Thyroid Disease	( )	( )	_____
Anemia	( )	( )	_____
Liver Disease	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Kidney Disease	( )	( )	_____
Diabetes	( )	( )	_____
Asthma/respiratory problems	( )	( )	_____
Stomach or intestinal problems	( )	( )	_____
Cancer (type: _____)	( )	( )	_____
Fibromyalgia	( )	( )	_____
Heart Disease	( )	( )	_____
Epilepsy or seizures	( )	( )	_____
Chronic Pain	( )	( )	_____
High Cholesterol	( )	( )	_____
High Blood Pressure	( )	( )	_____
Head Trauma	( )	( )	_____
Fibromyalgia	( )	( )	_____
Other: _____	( )	( )	_____

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APPOINTMENTS

New Patient Appointments

- Schedule your initial appointment (intake) by calling the main line at 720-683-6997 and leaving a detailed message in the *New Patient Inquiries* mailbox. You may also submit a new patient inquiry on our website at www.thearetecenter.com under *Contact Us*. Kindly allow two business days for a response.

Existing Clients

- *The Arete Center does not provide emergency services. If you experience an emergency, immediately contact 9-1-1.*
- Please DO NOT leave urgent messages in the general voicemail box or send urgent messages to welcome@thearetecenter.com, as the clinical staff does not monitor them.
- Follow-up appointments will generally be scheduled with your clinician in person during your appointment. You may also schedule by emailing or calling them and leaving a message in their personal voice mailbox. If your practitioner allows booking through The Arete Center Patient Portal, you can access their calendar by logging into your account through our website or bookmarking the patient portal page.
- By creating a Patient Portal account, you authorize The Arete Center to send you email and/or text reminders for appointments.
- Confidentiality for electronic communications via email and text messages cannot be guaranteed. Phone calls are preferred for the exchange of clinical information.
- Patients prescribed medication by a physician at the Arete Center must meet with their provider every six(6) months (minimum) for ongoing medication management and/or follow the recommendation of the prescribing physician. Failure to schedule and maintain regular visits with your provider can result in the termination of care (please see below).

Initials _____

LATE SHOWS, NO-SHOWS, AND CANCELLATIONS

Canceling Appointments

- line or their personal Arete Center email address to make arrangements.

No-Shows / Late Cancellations

- You will be charged in full if you are a no-show for an appointment without providing 24-hour advance notice.
- Your provider may refer you to another local provider if you have two or more no-shows or same-day cancellations.
- If you fail to attend an intake appointment or cancel within 24 hours of an intake appointment, The Arete Center reserves the right to charge you in full for the missed appointment and refer you to another local provider.

Late Arrivals

- A late arrival impacts your provider's ability to deliver effective clinical care. For any late arrival, you will be charged for the entire scheduled appointment.
- If you arrive late for your appointment, your provider will endeavor to accommodate the delayed start time and complete the remainder of your scheduled session. Your provider is not responsible for compensating you for the missed time. If you arrive more than 15 minutes beyond your scheduled start time (10 minutes for 25-minute sessions), your provider may not be able to accommodate you; if this is the case, you will be offered a rescheduled time at the provider's convenience, and you will be responsible for the missed appointment fee.

If there is a late cancellation or no-show fee, I understand that my provider will send an invoice for the missed appointment fee. If the invoice is not paid in full prior to my next appointment, that no-show or late payment fee will be added to the following appointment fee. I, the undersigned, agree that regardless of my insurance coverage, I am financially responsible for all charges generated for this patient. I understand that unpaid balances over 30 days past due may be referred to a collection agency.

Initials _____

COMMUNICATIONS POLICY

Phone Calls

- The Arete Center does not provide emergency services. In the case of an emergency at any time of day or night, clients should call 911 or go to the nearest emergency room.
- Arete Center and individual provider emails and voicemails are not monitored during off-business hours.
- Practitioners will return brief phone calls for administrative or scheduling matters within two business days for inquiries received during regular business hours. If a practitioner is out of the office and unavailable, they will leave an outgoing email and voicemail with their schedule.
- For phone calls requiring ten(10) or more minutes of your Arete Center provider's time, please schedule a phone appointment. There will be a standard charge for these phone calls based on the time spent per call. Please refer to the fee schedule for additional information.
- Please note that most insurance companies will not reimburse phone consultation fees.

Electronic Communications

- The Arete Center prefers clients to contact The Arete Center by phone call or email during business hours. Your provider will inform you if text messaging is a viable means of communication for some issues, typically scheduling only.
- Providers at The Arete Center do not accept "friend" or "contact" requests on any social media platform (e.g., LinkedIn ©, Facebook ©, Instagram ©, etc.). There are no exceptions to this policy.
- By agreeing to communicate via email, internet, or text message, you are assuming a certain degree of risk of breach of privacy. The Arete Center cannot ensure the confidentiality of any electronic communications against purposeful or accidental network interception.
- The Arete Center cautions you against emailing anything of a very private nature. Your provider will save email correspondence with you, which will be considered part of the medical record; therefore, you should assume that electronic communications may not be confidential and will be included in your medical chart.
- Never send emails of an urgent or emergent nature. Your provider will check your email regularly; however, re-email or call our office if you have yet to receive a reply within two(2) business days.
- To protect your privacy, be prudent in how you store treatment-related emails:
    - Ensure they are protected from unauthorized access by using and guarding your passwords.
    - Consider deleting emails you do not want others to see, followed by emptying your trash or recycle bins.
    - Emails sent from a workplace computer or account may be the property of your employer.

Initials_____

MEDICATION MANAGEMENT AND REFILLS

Patient Responsibilities

- You should make appointments at least three weeks before needing a refill on your medication.
- Please schedule your appointments to coincide with medication refill needs.
- For your safety, Dr. Walick will only call in prescriptions for current patients who maintain their *regularly scheduled appointments*.
- For Schedule II medication refills (i.e., stimulants), you will require an electronic prescription by Colorado State Law.
- While we intend to avoid any lapse in medication(s) for our patients, Dr. Walick will not refill a prescription(s) if you have failed to make regular follow-up appointments. All patients receiving Schedule II medication refills must have appointments scheduled and be in care at a minimum every six months.

Refills

- Refill requests should be made at least three(3) business days before your medication runs out.
    - Please email Dr. David Walick at dave@thearetecenter.com with your refill requests. Your request should include:
        - name of the patient
        - the medication needed
        - name of the pharmacy
- If you are changing pharmacies, please notify Dr. Walick when the medication refill is requested.
- For your safety, Dr. Walick will not call in medication refills over the weekend except in emergencies.
- Refill requests made outside of regular business hours will be billed at $25 unless you have made prior arrangements with your provider.
- There is an annual charge of $50 (per medication) for any prior authorization.

Initials_____

Releases of Information

For patient safety, every patient who is prescribed medication by The Arete Center must sign a release of information which permits the patient's provider at The Arete Center to request their most recent medical history and physical, a problem list, and a medication list from any other medical practitioner who is prescribing the patient medication. This release also allows The Arete Center to provide a patient's other practitioners with a list of medications currently prescribed by The Arete Center.

Initials_____

Transfer of Care or Termination

- Please notify your clinician at The Arete Center if you transfer care to another provider or resume care with your primary care provider.
- The Arete Center reserves the right to terminate and transfer care. In these instances, The Arete Center will provide you with one(1) month of medication (if indicated) and a list of local providers.
- Patients with two(2) or more no-shows or same-day cancellations may have care terminated and be referred to another local provider.

Initials_____

I have read and understand the preceding information. I have had the opportunity to ask questions about the policy. I agree to abide by the aforementioned policies. I acknowledge that I have received a copy of this policy statement.

Patient Name: _____

Patient Signature (if an adult):_____

Guardian's Name (if applicable): _____

Guardian's Signature (if applicable):_____

Date: _____

THE ARETE CENTER 2023 FEES AND PAYMENT POLICIES

2023 Arete Center Fees

Psychology Services

Service	Duration	Fee
Initial intake / comprehensive diagnostic interview	90 minutes	$450
Psychotherapy	50 minutes	$220
Abbreviated Therapy	25 minutes	$125
Family / Couples Therapy	75 minutes	$275
Initial intake / comprehensive diagnostic interview (Postdoc)	90 minutes	$300
Psychotherapy (Postdoc)	50 minutes	$150
Family Therapy (Postdoc)	75 minutes	$ 225
Family / Couples Therapy (Postdoc)	50 minutes	$150

Psychiatry Services

Service	Duration	Fee
Initial intake / comprehensive diagnostic interview	90 minutes	$450
Medication Management & Psychotherapy	50 minutes	$300
Medication Management	25 minutes	$150

Other Fees

Service	Fee
There will be a routine charge for phone calls longer than 10 minutes, billed at $50 per each additional 10 minutes	$50 per 10-minute increment
Medication refills requested fewer than 3 business days in advance, or after-hours refill requests	$25 per refill
There is a charge of $50 dollars per 10 minutes for disability, ESA, and school letters/IEPs.	$50 per 10-minute increment
There is an annual charge of $50 dollars (per medication) for any prior authorizations.	$50 annually per medication

FEE POLICY

The Arete Center and its providers do not currently contract with any insurance carriers.

- Visits with providers at The Arete Center are considered "out of network." Any reimbursement from your insurance company is based solely on your insurance policy. Please check with your insurance company as to whether or not you qualify for out-of-network benefits.
- After payment is received, your provider can send you a detailed invoice for out-of-network reimbursement that you can submit to your insurance provider (if you qualify for out-of-network benefits).
- This practice does not accept third-party insurance payments, including Medicaid and Medicare.
- Due to Medicaid policies, we cannot render services to Medicaid recipients. By signing this form, you, as the patient or responsible party for the patient (i.e., the parent or legal guardian), acknowledges that the patient being treated at the Arete Center is not a Medicaid recipient. Furthermore, you agree to notify the Arete Center PLLC and your treatment provider(s) individual business entities if you subsequently become a Medicaid recipient after receiving care from the Arete Center PLLC or its providers.

Payment Policies for Professional Services

- Payment for services is expected at the time of appointment unless other arrangements have been made in advance.
- Phone consultations will be charged at the hourly rate.
- Accepted payment methods include check, cash, or credit card (i.e., MasterCard, Visa, or American Express). Checks must be made out to your provider at the time of service.
- If payment for services exceeds 30 days from the time of service, your account will be turned over to a collection agency, an attorney, or small claims court, and any necessary identifying information may be disclosed for collection of payment.

By signing this form, you acknowledge that:

- Payment is due at the time of service.
- If for any reason, I do not pay at the time of the appointment, I understand that I will receive an electronic invoice for the applicable fee. I understand that payment is expected within two(2) business days.
- By signing, I agree that I am not a Medicaid recipient. I understand that my provider or providers at the Arete Center PLLC may be individual businesses responsible for providing mental healthcare services. By signing this form, I agree that I have carefully reviewed all information in this document.

I have read and understood the preceding information. I have had the opportunity to ask questions about the policy. I agree to abide by the aforementioned policies. I acknowledge that I have received a copy of this policy statement.

Patient Name: _____

Patient Signature (if an adult):_____

Guardian's Name (if applicable): _____

Guardian's Signature (if applicable):_____

Date: _____

CREDIT CARD AUTHORIZATION

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

___ VISA ___ Mastercard ___ American Express

Name as it appears on card _____

Credit / Debit Card Number: _____ - _____ - _____ - _____

Billing Zip Code: _____ Security Code:_____ Exp. Date:_____/_____

I/we authorize my provider from The Arete Center, P-LLC, to bill the above credit / debit card for professional services as outlined in the Policies. I will notify The Arete Center, P-LLC, in writing if I no longer want my credit / debit card billed. Additionally, I authorize a provider from the Arete Center, P-LLC (herein may be referred to as the "Arete Center" or "the practice") to charge the above credit card when the patient does not give advance notice for a late-cancellation or no-show, as per the Practice Policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

_____

Signature of Cardholder / Responsible Party Date Signed

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This notice describes how health information about you may be used and disclosed and how you can access this information. All requests regarding your health information must be submitted in writing to the address on this form.

You May…

Obtain a Copy of Your Medical Record:

- You can ask to see or receive an electronic or paper copy of your medical record and other health information The Arete Center has about you. Please submit a written request for this information to the address on this form.
- The therapist's personal notes documenting or analyzing the contents of counseling sessions are called psychotherapy notes, and access to these notes is excluded from your right to view or receive a copy. Access to psychotherapy notes will be decided at the sole discretion of The Arete Center.
- The Arete Center will provide a copy or a summary of your health information at our earliest convenience. You may be charged a reasonable, cost-based fee for this service.

Request Corrections to Your Medical Record:

- You can ask The Arete Center to correct health information about you that you think is incorrect or incomplete. The Arete Center may say "no" to your request, but you will be informed of why in writing within 60 days.

Request Confidential Communication:

- You can ask The Arete Center to contact you in a specific way (for example, by home or office phone) or to send mail to a particular address.

Choose Someone to Act for You:

- If you have given someone medical power of attorney, or if someone is your legal guardian, that person is entitled to exercise your rights and make choices about your health information.
- The Arete Center will verify that the person has the authority to act for you before any action is taken.

Get a Copy of this Privacy Notice:

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. The Arete Center will provide you with a paper copy promptly.

If Your Health Information Needs to Be Disclosed

You may request that The Arete Center share your health information with another entity, such as another provider, residential facility, or treatment program. A signed authorization may be required for this information to be sent to another entity.

How Your Information Will Be Shared

The Arete Center will generally use or share your health information in the following ways:

To Treat You: To share it with other professionals treating you.

To Run The Arete Center: To run our practice, improve your care, and contact you when necessary.

To Comply with the Law: To comply with the law in certain situations, such as:

- Reporting suspected abuse, neglect, or domestic violence;
- Preventing or reducing a serious threat to anyone's health or safety
- In response to a court order or a subpoena.

Responsibilities of The Arete Center

- We will maintain the privacy and security of your health information.
- We will let you know if a breach may have compromised your information's privacy or security.
- We will follow the duties and privacy practices described in this notice and provide you with a copy.
- We will not use or share your information other than as described here unless you confirm with us in writing. If you tell us we can, you may change your mind anytime.

Changes to the Terms of This Notice

We can change the terms of these policies, which will apply to all information we have about you. The new policies will be available upon request.

If you have any concerns, questions, or requests, please contact The Arete Center at:

The Arete Center PLLC
7180 East Orchard Road, Suite 201
Centennial, CO 80111
(720) 683-6997

Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I, _____, hereby acknowledge that I received a copy of The Arete Center's Privacy Policies. I understand that signing does not mean that I have agreed to any special uses or disclosures of my health records.*

_____ _____

Client/Personal Representative's Signature Date

_____

Client/Personal Representative's Printed Name

** You may refuse to sign this Acknowledgement, but that refusal does not prevent The Arete Center from using or disclosing health information. If you refuse to sign, The Arete Center will keep a record of the refusal.*

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STANDARD NOTICE

"Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call the No Surprises Help Desk at 1-800-985-3059.