New Client Information Sheet

Client's name: ____________________________ Date: ________________________
Address: ____
City, State: ____ Zip: ________________
Phone numbers ***with area code*** Home: (___)-____________ Work: (___)-__________
Cell: (___)-____________
Birth date: ________________ Age: ____ Social Security Number: ______________
(If client is under 18: Parent's name(s): ____)
Employer: ____
Position: ____________________ For how long?____________
Your education: ____
Marital/relationship status: ______________ Spouse/partner's name: ______________
Spouse/partner's age and sex: ________ How long together? ____________________
Spouse/partner's education: ________________ Spouse/partner's occupation: ____________
Names and ages of all children in the home: ____
Who referred you to Horizons?____
Who shall we contact in case of emergency? Name:________________Phone (___)__________

Insurance Information

Policy Holder's Name: ______________________________ DOB: __________
Policy Holder's SSN: ____________________
Deductible: $__________ Has it been met? __________
Copayment (amount *not* covered by your insurance for each visit): $____________________
Who will pay noninsured balance? ________________________________
If you are required to get preauthorization, have you done so? _________ # visits authorized: _______

Other Insurance

Spouse's Insurance (if any): Name of Plan: ____________________
Spouse's DOB: ____________ Contract #: __________________ Group #: ____________
Other Insurance Type: ________________________________
Deductible: $__________ Has it been met? __________
Copayment (amount *not* covered by your insurance for each visit): $____________________

In this box, please indicate the address and telephone number you want us to use to when sending bills or when we need to contact you. If this box is left blank, we will use the address and any of the telephone numbers you have provided above.

If you do *not* want us to leave a message on your answering machine, please tell us how you want us to reach you by phone:

All clients using health insurance please sign below

I hereby grant authorization to Horizons Counseling Services, Inc, to release any Protected Health Information (except Psychotherapy Notes) to my insurance company that is necessary for billing, or to process my claim for payment of services. I authorize my insurance company to send payment directly to Horizons for all services provided. I also authorize Horizons to release claims forms (containing Protected Health Information but not Psychotherapy Notes) and supporting documentation to the Ohio Department of Insurance if Horizons files a claim against my insurance company under the Ohio Prompt Payment Law. I agree that a photocopy of this authorization shall be as valid as the original.

________________________________ ________________________
Signature Date

Name: ______________________________ Date: ______________________________
List any allergies you have: __________________________________ ❑None
Primary Care Physician: ________________ Address: ____________________________
City: __________________ State: _________________ ZIP: ____________________
Primary Care Physician's phone number: (____) ________________ ____________________
Date of your most recent physical examination: ____________________

What kind of problem brings you to Horizons?

____
____
____

List all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

List all current or past health problems, and any major operations:

Current	Past

List all therapists you have seen, and dates you saw them:

____
____
____
____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:

____
____
____
____
____

Please indicate which of these substances you currently use:

Substance	Amount used	How many times per month do you use it?
❑Cigarettes		
❑Alcohol		
❑Marijuana		
❑Cocaine or crack		
❑Heroin		
❑Pills not prescribed for me		
❑LSD		
❑Other (please list):		

Please indicate if you are having any of the following problems, or if you had them in the past

	I have this now	I had it in the past
Difficulty falling asleep or staying asleep	❑	❑
Sleeping too much	❑	❑
Change in appetite, weight loss, or weight gain	❑	❑
Frequent crying	❑	❑
Thoughts of killing or hurting myself	❑	❑
Attempts to kill or hurt myself	❑	❑
Problems concentrating	❑	❑
Periods of daily sadness lasting more than two weeks	❑	❑
Little or no interest in sex	❑	❑
I feel tired almost every day	❑	❑
Problems remembering things	❑	❑
Periods of time in which I felt so good or so hyper that other people thought I was not my usual self *or* I was so hyper that I got into trouble	❑	❑
I startle easily	❑	❑
Can't stop remembering upsetting past events	❑	❑
Difficulty controlling my temper	❑	❑
I physically hurt other people	❑	❑
I break things sometimes	❑	❑
I worry a lot	❑	❑
Panic attacks or anxiety attacks	❑	❑
Feeling that I or my surroundings are unreal	❑	❑
Made myself throw up in order to lose weight	❑	❑
Used laxatives or exercised excessively to lose weight	❑	❑
I often feel like I am an outsider	❑	❑
Sexual problems	❑	❑
Worry that something is wrong with my body	❑	❑
Frequent arguments with the people I live with	❑	❑
Other (please list):		

Reviewed by ______________________________ Date ______________________________

Horizons Counseling Services, Inc.

This form has four purposes:

(1) *It tells you what to expect from psychotherapy.* Your first visit will help us get a general understanding of your situation in order to determine how we might best help you. Because we want you to participate actively in planning your counseling, don't hesitate to ask questions. Psychotherapy is a way of talking through your problems in order to begin resolving them. You will need to take an active part in psychotherapy by working on and thinking about the things you talk about with your therapist. Psychotherapy has been shown to have many benefits. However, there are no guaranteed results, and at times a psychotherapy session may leave you with unhappy feelings. When it is effective, psychotherapy often leads to better relationships, solutions to specific problems, and feeling much less distressed.

(2) *This form serves an Agreement between you and Horizons*. You may revoke (cancel) this Agreement in writing at any time. That revocation will be binding on Horizons unless we have already relied on this Agreement to take action, *or* if your health insurer requires Horizons to send information needed in order to process claims made for our services, *or* if you have not paid your bill in full.

(3) *This form also contains information about a federal law that affects your privacy rights*. This law, called HIPAA (Health Insurance Portability and Accountability Act) regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices. The Notice, included in this Agreement, explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. We will give you a copy of this Agreement, including the Notice.

(4) *This form explains our policies*. Please let your therapist know if you have concerns or questions about these policies.

APPOINTMENTS

Individual and family sessions last 45-50 minutes and can be scheduled through the secretary or your therapist. *If you cancel an appointment, notify us at least 24 hours before the session, or you will be charged the full hourly fee for the time you reserved for the appointment. Insurance does not pay charges for reserved time; you will personally be responsible for any such charges.* However, if you call in advance to cancel an appointment because you are ill, there will be no charge.

FEES, HEALTH INSURANCE, AND MANAGED CARE

This packet contains a separate page to clarify fee arrangements. Please read it carefully, and ask your therapist any questions that you have concerning payment arrangements. For problems involving payments and insurance, please call our secretary Monday, Wednesday, and Thursday, 9 a.m. to 5 p.m.; or Friday mornings.

Many insurance plans are managed care plans. Under a managed care plan, the insurance company periodically requires the therapist to submit your diagnosis, progress, and treatment plan to their reviewer, who then determines if further treatment is medically necessary. We want you to know that if you have a managed care insurance plan, this information will be released to the reviewers. If you don't want us to release this information, you can choose not to use your insurance coverage and pay for our services yourself at the time of each visit.

TELEPHONE CALLS

Please try to make any telephone calls to your therapist during normal business hours, Monday through Friday, 9-5. Lengthy telephone consultations may be billed at our standard hourly rate for professional service. *In emergencies, our 24-hour answering service can contact your therapist (an emergency is generally a situation in which you are in danger of hurting yourself or someone else). If the emergency is serious and you cannot wait until your therapist returns the call, please call the 24-hour mental health emergency number at 216-623-6888, or go to a hospital emergency room.*

CONFIDENTIALITY AND FILES: NOTICE OF PRIVACY POLICIES AND PRACTICES

Federal and State laws governing confidentiality can be quite complex. This Notice explains some specific Patient Rights that you have under these laws. We will maintain a Clinical Record file on your case, which is the property of Horizons. You may examine and/or receive a copy of your file *if* you request it in writing *and* the request is signed by you *and* dated not more than 60 days from the date it is submitted. There may be a charge for writing reports or for copying materials.

Please note: If you are being seen in couples, group, or family therapy, Ohio laws concerning confidentiality are not clear. Horizons will not release information to other parties without your written permission except when allowed or required to do so by State or Federal law, unless a court order requires us to release information about your case.

❖ USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS[*]

Horizons may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations":
  - *Treatment* is when Horizons provides, coordinates and manages your health care and other services related to your health care.
  - *Payment* is when Horizons obtains reimbursement for your healthcare. Horizons uses collections agencies, an accountant, and technical support service for our billing software. As required by HIPAA, these businesses have signed contracts with us in which they promise to maintain the confidentiality of protected health information except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and a blank copy of the contract.
  - *Health Care Operations* are activities that relate to the performance and operation of Horizons Counseling Services, Inc.
- "*Use*" means activities within Horizons' practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. Your therapist practices with other mental health professionals and also employs secretarial staff. In most cases, your therapist needs to share information with secretarial staff for purposes such as billing, scheduling, and quality assurance. Also, Horizons' clinical staff routinely consult with each other concerning our clients. Please let your therapist know if you would prefer that other clinical staff *not* be consulted about your case. All of the professional staff are bound by the same rules of confidentiality, and all secretarial staff have training in privacy rules and have agreed not to release any information outside of the practice without permission of a professional staff member.
- "*Disclosure*" means activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties. Your therapist may find it helpful to share information with your primary care physician or other health and mental health professionals who are currently treating you. Your signature on this Agreement is written, advance consent for us to release information to these professionals. A record of these disclosures will be kept in your Clinical Record. ❑ **Check here if do NOT wish us to release any information to other mental health and health professionals who are currently treating you**. Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During consultations, your therapist makes every effort to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. The therapist will note all consultations in your Clinical Record.

- **Uses and Disclosures Requiring Authorization**

Your therapist may use or disclose PHI for purposes outside of treatment, payment, and health care operations when authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your therapist is asked for information for purposes outside of treatment, payment and health care operations, she/he will obtain an authorization from you before releasing this information. Your therapist will also need to obtain a separate authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which your therapist has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided

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[*] Horizons reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that is maintained. Horizons will provide you with a revised notice by posting the revisions in the waiting room for your inspection.

each revocation is in writing. You may not revoke an authorization to the extent that (1) Your therapist has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

- **Uses and Disclosures with Neither Consent nor Authorization**

Your therapist may use or disclose PHI without your consent or authorization in the following circumstances:

  - **Child Abuse:** If your therapist knows or suspects that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired person under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, she/he is required by law to report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.
  - **Elder Abuse:** If your therapist has reasonable cause to believe that an elder is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, she/he is required by law to immediately report such belief to the County Department of Job and Family Services.
  - **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the psychologist-client (or social work-client) privilege law. Horizons cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court orders Horizons to disclose information, we are required to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
  - **Serious Threat to Health or Safety:** If your therapist believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, she/he may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to your therapist an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and your therapist believes you have the intent and ability to carry out the threat, then she/he is required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
  - **Worker's Compensation:** If you file a worker's compensation claim, your therapist may be required to give your mental health information to relevant parties and officials.
  - **If the client is a minor:** Both parents have access to the minor client's complete Clinical Record, including Psychotherapy Notes, unless there is a court order prohibiting one of the parents from access.
  - **If a government agency** (such as Medicare) is requesting the information for health oversight activities, Horizons may be required to provide it to them.
  - **If a client files a complaint** or lawsuit against Horizons or any of its staff, Horizons may disclose relevant information regarding that patient in order to defend itself.
  - **Horizons staff may present** disguised case material in seminars, classes, or scientific writings; in this situation, all identifying information and Protected Health Information is removed and client anonymity is maintained.
  - **Your health insurance plan** has the right to review your Clinical Records for any services you have asked them to pay for. Unless your treatment is being paid for by a Workers Compensation plan, a health insurance company is *not* entitled to see Psychotherapy Notes, which are detailed notes your therapist may make concerning what you have talked about in therapy. However, they *are* entitled to see PHI in your clinical record, including information about dates of therapy, symptoms, your diagnosis, your overall progress towards those goals, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

❖ CLIENT'S RIGHTS AND PSYCHOLOGIST'S DUTIES:

- **Client Rights:**
  - *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, your therapist is not required to agree to a restriction you request.
  - *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative

means and at alternative locations. For example, if you don't want family members to know you are seeing a therapist, you can have your bills sent to an alternate address.
  - *Right to Inspect and Copy* – You have the right to inspect and/or obtain a copy of your, or your minor child's, PHI and psychotherapy notes in your therapist's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. There will be a charge for records returned from remote/off site locations and for copies made.
  - *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your therapist may deny your request.
  - *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described on page 6 of this Notice).
  - *Right to a Paper Copy* – You have the right to obtain a paper copy of the Privacy Notice from your therapist upon request, even if you have agreed to receive the Notice electronically.
- **Therapist's Duties:**
  - Your therapist is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI.
  - Horizons reserves the right to change the privacy policies and practices described in this notice. Unless your therapist notifies you of such changes, however, the therapist is required to abide by the terms currently in effect.
  - If Horizons revises their policies and procedures, they will be posted in the waiting room for your inspection, at your convenience.

❖ **COMPLAINTS:**

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision your therapist made about access to your records, you may contact Susan Radbourne, Ph.D., (440) 845-9011. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Dr. Radbourne can provide you with the appropriate address upon request.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES INCLUDED ABOVE.

______________________________ ______________________________ ________________

Client or responsible party Witness Date

Horizons Counseling Services, Inc.

Fee Agreement

1. ***FEE:*** The fee for the initial consultation will be $__$140.00__. After that, your fee will be $__$110.00__ per __45____-minute individual, couples, or family session. The fee for group therapy will be $50 per session. Although health insurance may aid in payment, you alone are responsible for paying for psychological services and appointments at Horizons Counseling Services, Inc. ***If you cancel or do not keep an appointment without giving twenty-four hours' advance notice, you must pay for the time you have reserved***. Insurance companies do not pay for canceled appointments. If you are ill and call in advance to cancel your appointment, there will be no charge.

If your insurance company has contracted with Horizons to accept a lower fee, your deductible and any noninsured portion of each session's fee will be based on that contracted amount. If the insurance company decides to increase the fee that Horizons is allowed to charge, your deductible and any noninsured portion of each session's fee will be based on the increased amount. Sometimes managed care companies will authorize more sessions than your insurance benefits will pay for. If you see your therapist for visits *that are authorized* but not paid for by your insurance benefits, by signing this form you agree to pay Horizons' fee, as listed above, for each authorized visit that is not covered by your insurance benefits.

If your insurance company requires you to get authorization from them before seeing a therapist and you do not do so, you are responsible for payment in full of the fees listed above.

Occasionally, Horizons may increase its standard fee. If you are in therapy at Horizons when an increase is to occur, you will be notified in advance. At that time, your fee will be adjusted to the new fee, this fee agreement will be terminated, and you will be asked to sign a new agreement which reflects the new fee.

2. ***PAYMENT ARRANGEMENT***:

All accounts are payable in full within 30 days after billing. Overdue accounts may be charged interest at the rate of 10% per year.

__X___ STANDARD PAYMENT ARRANGEMENT: Payment for any deductible or noninsured portion of your fee is due before each session.

_____ ALTERNATIVE PAYMENT ARRANGEMENT:

3. ***COLLECTIONS PROCEDURES***: Horizons Counseling Services, Inc., reserves the right to collect any unpaid balance due to them. If a client is not making regular monthly payments on the account balance, Horizons may use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections action will become a part of your credit record. Clients will be notified in writing before Horizons takes action to collect.

4. ***LIMIT ON UNPAID BALANCE:*** Horizons may terminate treatment and refer the client elsewhere for continued care if the unpaid balance exceeds $500.00.

I have read and understood the above fee agreement, and I agree to abide by its terms.

______________________________ ______________

Name Date