

Child/Adolescent 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: _____
Mother's name: _____ Birth date: _____
Father's name: _____ Birth date: _____
Parents' marital/relationship status: _____ With whom does the child live: _____
Parent's employer(s): Mother: _____ Father: _____
Parents' position(s): Mother: _____ For how long? _____
Father: _____ For how long? _____
Child/teen's current school and grade: _____
Names and ages of other children in the home: _____
Who referred you to Horizons? _____
Who shall we contact in case of emergency? Name: _____ Phone () _____

<i>Insurance Information</i>	
Policy Holder's Name: _____	DOB: _____
Policy Holder's SSN: _____	
Deductible: \$ _____	Has it been met? _____
Copayment (amount <i>not</i> 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: _____	
<i>Other Insurance</i>	
Spouse's Insurance (if any): Name of Plan: _____	
Spouse's DOB: _____	Contract #: _____ Group #: _____
Other Insurance Type: _____	
Deductible: \$ _____	Has it been met? _____
Copayment (amount <i>not</i> covered by your insurance for each visit): \$ _____	

<p>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.</p>
<p>If you do <i>not</i> want us to leave a message on your answering machine, please tell us how you want us to reach you by phone:</p>

All clients using health insurance please sign below; parent must sign if client is under 18: 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

Parent or guardian please sign below: I hereby consent for Horizons Counseling Services, Inc., to provide treatment and evaluation to

Name: _____ Signature: _____ Date: _____

Name: _____ Date: _____
 List any allergies your child or teen has had: _____ None
 Primary Care Physician: _____ Address: _____
 City: _____ State: _____ ZIP: _____
 Primary Care Physician's phone number: (____) _____
 Date of most recent physical examination: _____

What brings you to Horizons?

List all current medications and dosages:

Name of medication	Dosage	Name of prescribing Doctor	When did he or she start taking it?

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

Current	Past

List all therapists your child or teen has seen, and dates of treatment:

List any substance abuse treatment or inpatient psychiatric treatment your child or teen has had, and the dates:

<u>Developmental milestones</u>	<u>Did this at age...</u>
Crawled	_____
Walked	_____
Spoke single words	_____
Spoke sentences	_____
Skipped	_____
Entered kindergarten	_____

List any developmental concerns you currently have about your child or teen:

Please indicate which of these substances your child or teen currently uses:

Substance	How much and how often?	
	Child/teen's use	Parents' use
<input type="checkbox"/> Cigarettes		
<input type="checkbox"/> Alcohol		
<input type="checkbox"/> Marijuana		
<input type="checkbox"/> Cocaine/crack		
<input type="checkbox"/> Heroin		
<input type="checkbox"/> Pills not prescribed for him or her		
<input type="checkbox"/> Hallucinogens		
<input type="checkbox"/> Other (please list):		

Please indicate if your child or teen is having any of the following problems, or if he or she had them in the past

	Has this now	Had it in the past
Difficulty falling asleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>
School performance has gone down	<input type="checkbox"/>	<input type="checkbox"/>
Frequently defiant	<input type="checkbox"/>	<input type="checkbox"/>
Toileting problems	<input type="checkbox"/>	<input type="checkbox"/>
Refuses to go to school, or cuts classes frequently	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate sexual behavior	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite, weight loss, or weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent crying	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks or anxiety attacks	<input type="checkbox"/>	<input type="checkbox"/>
Talks about killing or hurting self	<input type="checkbox"/>	<input type="checkbox"/>
Attempts to kill or hurt self	<input type="checkbox"/>	<input type="checkbox"/>
Problems concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Problems remembering things	<input type="checkbox"/>	<input type="checkbox"/>
Periods of daily sadness lasting more than two weeks	<input type="checkbox"/>	<input type="checkbox"/>
Startles easily	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty controlling temper	<input type="checkbox"/>	<input type="checkbox"/>
Physically hurts other people	<input type="checkbox"/>	<input type="checkbox"/>
Throws or break things	<input type="checkbox"/>	<input type="checkbox"/>
Worries a lot	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of feeling tired	<input type="checkbox"/>	<input type="checkbox"/>
Made self throw up in order to lose weight	<input type="checkbox"/>	<input type="checkbox"/>
Used laxatives or exercised excessively to lose weight	<input type="checkbox"/>	<input type="checkbox"/>
Worry that something is wrong with his or her body	<input type="checkbox"/>	<input type="checkbox"/>
Frequently argues with other family members	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list):		

Reviewed by _____ Date _____

Horizons Counseling Services, Inc. - Services and Fee Agreement

Welcome to Horizons. This document contains important information about our professional services and business practices. It also details our obligations and your rights under the Health Insurance Portability and Accountability Act (HIPAA), a federal law that regulates the use and disclosure of your Protected Health Information (PHI). Protected health information is health information that is individually identifiable. HIPAA requires that we notify you of our privacy policies and these are described in detail in the Confidentiality and Privacy Policies section below.

APPOINTMENTS

During the initial consultation, your therapist will attempt to gain a general understanding of your situation and determine the most appropriate treatment. We believe it is important for clients to take an active part in their treatment, so don't hesitate to ask questions. Psychotherapy has been shown to have many benefits - better relationships, solutions to specific problems, feeling less distressed. However, there are no guarantees of progress.

Individual and family sessions last 45-50 minutes. *If you cancel an appointment, notify us at least 24 hours before the scheduled time, or you will be billed the usual hourly rate. Insurance will not cover charges for unkept/late cancelled appointments, so you will personally be responsible for such charges.* However, there will be no charge if you call in advance (at least 24 hours before appointment time) to cancel an appointment. There may be valid reasons such as illness. If you have a contagious illness, please call to cancel even without 24 hours notice - do not come to the office.

FEES AND HEALTH INSURANCE

The fee for the initial consultation is \$160. Subsequent 45-50 minute sessions are \$130. Although health insurance may aid in payment, you alone are responsible for paying for services.

Your therapist will answer any questions about payment arrangements. For routine problems involving payments and insurance, please call our office staff Monday through Thursday, 9 AM to 5 PM or Friday 9 AM to 12 Noon.

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

If an account is overdue, regular payments are not being made, and no provision for payment has been made, we may turn the account over to a collection agency or attorney, as authorized by state or federal law. We reserve the right to collect any unpaid balance due. Clients will be notified in writing before Horizons takes such action to collect.

Most health plans cover *part* of our fee. There are two kinds costs you may incur that are not covered by your insurance company - deductibles and co-pays. Please pay any non-insured portion of the fee before each visit. Horizons contracts with some insurance companies to cover our services at a rate lower than our standard fee. In such cases, your account balance will be adjusted when we receive insurance payment. However, if the insurance pays less than 100% of the contracted fee, you will owe any balance up to 100% of that contracted fee. Deductibles and co-pays determined by your insurance company may change during the course of your treatment.

Sometimes health insurance 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 plan.

X STANDARD PAYMENT ARRANGEMENT: Payment for any deductible or noninsured portion of your fee is due before each session. This applies unless you initial “Alternative Payment Arrangement” on the next line.

 ALTERNATIVE PAYMENT ARRANGEMENT: Initial this line AND discuss with your therapist.

CONFIDENTIALITY AND PRIVACY POLICIES

Horizons will maintain a clinical record of your case, which is the property of Horizons. This includes your protected health information (PHI). Your therapist and Horizons are required by law to maintain the privacy of your PHI. In most situations, Horizons can release your PHI to others *only* if you permit us to do so by signing a written authorization form. However, there are situations in which we are permitted to use and disclose your PHI for the purposes of treatment, payment, and health care operations. **Your signature on this agreement is written, advance consent for the following uses and releases of information:**

- Your therapist practices with other mental health professionals and employs secretarial staff. In most cases, your therapist needs to share information with them for purposes such as billing, scheduling, and quality assurance. Also, Horizons’ clinical staff routinely consults 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. Our professional staff is bound by the same rules of confidentiality.
- 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 clients. The other professionals are also legally bound to keep the information confidential. The therapist will note all consultations in your Clinical Record.
- 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 consent for us to release information to these professionals. A record of these disclosures will be kept in your Clinical Record.

 Initial here to direct us to NOT RELEASE any information to other mental health and health professionals who are currently treating you.

- 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 PHI 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.
- If you are being seen in couples, family or group therapy, you should be aware that 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.

In some situations we are permitted or required to disclose information *without* either your consent or authorization:

- If, in our judgment, a client is likely to seriously harm himself/herself or someone else.
- If we have reason to believe that abuse of a child or senior citizen has taken or is taking place.

- 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 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 privilege law. Horizons cannot provide any information without your (or your personal or legal representative's) written authorization. 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.
- If a government agency (such as Medicare) is requesting the information for health oversight activities, Horizons may be required to provide it for them.
- If a client files a complaint or lawsuit against Horizons or any of its staff, Horizons may disclose relevant information regarding that client in order to defend itself.
- If a client files a worker's compensation claim, the client must sign an authorization so that Horizons may release the information, records or reports relevant to the claim.
- Horizons staff may present disguised case material in seminars, classes, or scientific writing. All identifying information is removed and client anonymity is maintained.
- Your health insurance plan has the right to review your Clinical Record for any services you have asked them to pay for. Health insurance companies (with the exception of Worker's Compensation) are *not* entitled to see Psychotherapy Notes, which are notes your therapist may make describing or analyzing therapy sessions. These notes are kept separately from your clinical record. However, insurers *are* entitled to see PHI in your 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 health insurance company.

TELEPHONE AND EMAIL COMMUNICATIONS

Please try to make any telephone calls to your therapist during normal business hours. Lengthy telephone consultations may be billed at your usual hourly rate. *In emergencies, our 24-hour answering service can contact your therapist. If the emergency 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.*

Email is not a secure means of communication. Therefore confidentiality of content transmitted via email cannot be guaranteed. If you choose to use email to contact or communicate with your therapist, please be advised that Horizons and your therapist cannot be responsible for its confidentiality.

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 Katherine Kratz, PsyD, (440) 845-9011. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Dr. Kratz can provide you with that address upon request.

I HAVE READ THIS AGREEMENT AND WITH MY SIGNATURE AGREE TO ITS TERMS.

Client or responsible party
(Parent must sign for a minor)

Witness

Date