

New Client Information Sheet

Client's name: _____ Date: _____
Address: _____
City, State: _____ Zip: _____
Phone numbers *with area code* Home: ()- _____ Work: ()- _____
Birth date: _____ Age: _____ Social Security Number: _____
(If client is under 18: Parent's name(s): _____)
Employer (or parent's employer): _____
Position (or parents' position): _____ For how long? _____
Education: _____
Marital/relationship status: _____ Significant other's name: _____
Significant other's age and sex: _____ How long together? _____
Significant other's education: _____
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; 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

If the client is younger than 18, parent or guardian please sign below

I hereby consent for Horizons Counseling Services, Inc., to provide treatment and evaluation to _____
(name of client)

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? |
|--------------------|--------|----------------------------|-------------------------------|
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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 often? |
|--|-------------|------------|
| <input type="checkbox"/> Cigarettes | | |
| <input type="checkbox"/> Alcohol | | |
| <input type="checkbox"/> Marijuana | | |
| <input type="checkbox"/> Cocaine or crack | | |
| <input type="checkbox"/> Heroin | | |
| <input type="checkbox"/> Pills not prescribed for me | | |
| <input type="checkbox"/> LSD | | |
| <input type="checkbox"/> 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleeping too much | <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"/> |
| Thoughts of killing or hurting myself | <input type="checkbox"/> | <input type="checkbox"/> |
| Attempts to kill or hurt myself | <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"/> |
| I startle easily | <input type="checkbox"/> | <input type="checkbox"/> |
| Can't stop remembering upsetting past events | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty controlling my temper | <input type="checkbox"/> | <input type="checkbox"/> |
| I physically hurt other people | <input type="checkbox"/> | <input type="checkbox"/> |
| I break things sometimes | <input type="checkbox"/> | <input type="checkbox"/> |
| I worry a lot | <input type="checkbox"/> | <input type="checkbox"/> |
| Little or no interest in sex | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel tired almost every day | <input type="checkbox"/> | <input type="checkbox"/> |
| Feelings of unreality | <input type="checkbox"/> | <input type="checkbox"/> |
| Made myself 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"/> |
| I often feel like I am an outsider | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Worry that something is wrong with my body | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent arguments with the people I live with | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list): | | |

Reviewed by _____ Date _____

Horizons Counseling Services, Inc.

This form has three purposes. First, it tells you about our procedures and policies concerning important aspects of your psychotherapy. Please let your therapist know if you have concerns about any of these policies. 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. Therapy often leads to better relationships, solutions to specific problems, and feeling much less distressed. However, there are no guarantees of what you will experience, and at times a psychotherapy session may leave you with unhappy feelings.

Second, this form is 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 it 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.

Finally, this form also contains information a new 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). The Notice, which is attached to 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. Please take home the Notice and read it before your next session; you and your therapist can discuss any questions you may have about it next time.

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. Your therapist will answer any questions about 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. If an account is overdue and no provision for payment has been made, we may turn the account over to a collection agency or lawyer, as authorized by state or federal law, and your failure to pay Horizons will show up on your credit history.

Most group health insurance plans cover *part* of our fee. Insurance claims require a diagnosis, which your therapist will discuss with you if you ask. There may be two kinds of noninsured costs to you: (1) a deductible, which is an amount you must pay before your insurance coverage begins to pay; and (2) many plans also have a copayment, which is a portion of the fee for each visit that you must pay yourself. Please pay any deductible and copayment before each visit. Horizons has contracted with some insurance companies to accept less than our standard fee as payment in full. If this is the case, your account balance will be adjusted when we receive payment from the insurance company. However, if the insurance pays less than 100% of the contracted fee, you will owe the balance of the fee up to 100% of the contracted fee.

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.

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

The laws governing confidentiality can be quite complex. The attached Notice explains some specific Patient Rights that you have under the HIPAA law.

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.

In most situations, Horizons can release information about your treatment to others *only* if you sign a written authorization form for each release. However, in other situations, Horizons needs only written, advance consent to release information. **Your signature on this agreement is written, advance consent for the following releases of information:**

- Your therapist practices with other mental health professionals and also 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 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.
- 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.
- 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.

- 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.

There are some situations where Horizons is permitted or required to disclose information without either your consent or authorization:

- If a client is clearly likely to seriously harm him/herself, we may be required to take action to prevent self-destruction.
- If there is a clear risk that a client plans to seriously harm another person, we may have a duty to warn the potential victim; or disclose the risk to appropriate public authorities.
- If a therapist suspects that abuse of a child or senior citizen may have taken place, the therapist is required to report the suspected abuse to the Department of Child and Family services.

- 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. 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.
- 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 patient 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 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 other Protected Health Information 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.

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 DESCRIBED ABOVE.

Client or responsible party

Witness

Date

Horizons Counseling Services, Inc.

Fee Agreement

1. **FEE:** The fee for the initial consultation will be \$ \$160.00 . After that, your fee will be \$ \$130.00 per 45 -minute 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.

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
(Parent must sign for a minor)

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: _____

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|---|
| What kind of problem brings you to Horizons? |
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| |
| |

List all current medications and dosages:

| Name of Medication | Dosage | Name of Prescribing Doctor | When did you start taking it? |
|--------------------|--------|----------------------------|-------------------------------|
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List all current or past health problems, and any major operations:

| | |
|----------------|-------------|
| Current | Past |
| | |
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| | |

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 often? |
|--|-------------|------------|
| <input type="checkbox"/> Cigarettes | | |
| <input type="checkbox"/> Alcohol | | |
| <input type="checkbox"/> Marijuana | | |
| <input type="checkbox"/> Cocaine or crack | | |
| <input type="checkbox"/> Heroin | | |
| <input type="checkbox"/> Pills not prescribed for me | | |
| <input type="checkbox"/> LSD | | |
| <input type="checkbox"/> 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleeping too much | <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"/> |
| Thoughts of killing or hurting myself | <input type="checkbox"/> | <input type="checkbox"/> |
| Attempts to kill or hurt myself | <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"/> |
| I startle easily | <input type="checkbox"/> | <input type="checkbox"/> |
| Can't stop remembering upsetting past events | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty controlling my temper | <input type="checkbox"/> | <input type="checkbox"/> |
| I physically hurt other people | <input type="checkbox"/> | <input type="checkbox"/> |
| I break things sometimes | <input type="checkbox"/> | <input type="checkbox"/> |
| I worry a lot | <input type="checkbox"/> | <input type="checkbox"/> |
| Little or no interest in sex | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel tired almost every day | <input type="checkbox"/> | <input type="checkbox"/> |
| Feelings of unreality | <input type="checkbox"/> | <input type="checkbox"/> |
| Made myself 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"/> |
| I often feel like I am an outsider | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Worry that something is wrong with my body | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent arguments with the people I live with | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list): | | |

Reviewed by _____ Date _____