Adult Intake Form – Horizons Counseling Services

Client's name: _____ Date: _____
Address: _____
City, State: _____ Zip: _____
If confidential billing address is different, please indicate here: _____
_____
Phone numbers: Home: _____ Work: _____ Cell:_____
OK to leave you a voice message? Which phone number(s)?_____
OK to leave you a text message? Which phone numbers(?) _____
OK to contact you by email? If YES, email address is _____
(see Services and Fee Agreement for limits of confidentiality for email and text messages)
Birth date: _____ Age: ____ Social Security Number: _____
Employer: _____
Position:_____ For how long? _____
Education: _____
Marital/relationship status:_____ Spouse/partner's name: _____
Spouse/partner's age and gender: _____ How long together? _____
Spouse/partner's education: _____ Spouse/partner's occupation: _____
Names and ages of ALL children, either in the home or living away from home: _____
_____
_____
Have you or a family member served in the military? Who? When? _____
_____
Who referred you to Horizons? _____
Contact in case of emergency? Name: _____ Phone _____

Please bring your insurance card(s) to the initial appointment.
Who will pay noninsured balance? _____
You may skip Primary and Secondary insurance information if we can copy your insurance card(s).

Primary Insurance
Policy Holder's Name: _____ DOB: _____
Policy Holder's SSN: _____

Secondary Insurance
Policy Holder's Name: _____ DOB: _____
Policy Holder's SSN: _____

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

What brings you to Horizons/What do you need help with?

Primary Care Physician: _____
Address: _____
City:_____ State:_____ Zip: _____
Phone number: _____
Approximate date of most recent physical examination: _____
List all allergies: _____ ❑None

You have my permission to contact my Primary Care Physician YES___ NO___

List all current medications:

Name of Medication	Dosage	Reason for taking	Prescribing Doctor	Start Date

List health problems and any major surgeries:

Current/Recent	Past

List all psychiatrists, psychologists, counselors you've seen, with approximate dates of treatment:

List any substance abuse treatment or inpatient psychiatric treatment with approximate dates:

Is there any other information you'd like us to know, which may help us in working with you?

Please indicate which substances you currently use:

Substance	Amount used	How often?	I'm concerned about my use
❑Cigarettes/nicotine			
❑Alcohol			
❑Marijuana			
❑Opiates			
❑Stimulants			
❑Others (please list):			

Check all that apply, either currently or in the past:

	Currently	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	❑	❑
Thoughts of harming other people	❑	❑
Problems concentrating	❑	❑
Periods of daily sadness lasting more than two weeks	❑	❑
Little or no interest in sex	❑	❑
Feel tired almost every day	❑	❑
Problems remembering things	❑	❑
Excessive hyperactivity or impulsive actions	❑	❑
Startle easily	❑	❑
Can't stop remembering upsetting past events	❑	❑
Difficulty controlling my temper	❑	❑
Physically hurt other people	❑	❑
Break things sometimes	❑	❑
Worry too much	❑	❑
Panic or anxiety attacks	❑	❑
Feel that I or my surroundings are unreal	❑	❑
Self-induced vomiting to lose weight	❑	❑
Use of laxatives or excessive exercise to lose weight	❑	❑
Often feel like I am an outsider	❑	❑
Sexual or gender concerns	❑	❑
Worry that something is wrong with my body	❑	❑
Relationship difficulties	❑	❑
Frequent arguments with the people I live with	❑	❑
Abusive relationships	❑	❑
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. HIPPA requires that we notify you of our privacy policies and these are described in detail in the Confidentiality and Privacy Policies section below.

APPOINTMENTS AND CANCELLATIONS

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. While it is likely that you will make progress, there are no guarantees.

If you cancel an appointment, you must notify us at least 24 hours before the scheduled time, or you will be billed the full session rate, not your copay. 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 at least 24 hours before the appointment time to cancel. There may be valid reasons such as illness, for cancelling without charge. 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

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 insurance companies to cover our services at a rate lower than our standard fee (see below). 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.

These are our fees for the following procedures (listed with the code numbers that may appear on the explanation of benefits statement from your insurance carrier):
90791- Diagnostic Evaluation - $175
90832- Individual psychotherapy 30 minutes (16-37 minutes) – $85
90834- Individual psychotherapy 45 minutes (38-52 minutes) – $130
90837- Individual psychotherapy 60 minutes (53 minutes and above) – $175
(The billing code for 90 minute sessions has been eliminated)
90846/90847- Family psychotherapy, client not present/client present - $140

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.

_____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 heath 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.
- You have the right to restrict certain disclosures of PHI to your health insurance plan when you pay out-of-pocket in full for our services.

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 child's complete Clinical Record, including Psychotherapy Notes (see below), 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. Any disclosure of Psychotherapy Notes (with the exception of Worker's Compensation) would requires a separate written authorization from you. 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.

For more on your rights as a client, see our *Notice of Policies and Practices to Protect Privacy of Your Heath Information***,** available in hard copy from our office or as a download from our website.

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

Intake Information for Spouse/Partner

Spouse/partner's name: _____ Date: _____
Address: _____
City, State: _____ Zip: _____
Phone numbers: Home: _____ Work: _____
Cell: _____
Birth date: _____ Age: ____ Social Security Number: _____

What brings you to Horizons/What do you need help with?

_____

_____

Primary Care Physician: _____
Address: _____
City:_____ State:_____ Zip: _____
Phone number: _____
Approximate date of most recent physical examination: _____
List all allergies: _____ ❑None

You have my permission to contact my Primary Care Physician YES___ NO___

List all current medications:

Name of Medication	Dosage	Reason for taking	Prescribing Doctor	Start Date

List health problems and any major surgeries:

Current/Recent	Past

List all psychiatrists, psychologists, counselors you've seen, with approximate dates of treatment:

_____

_____

_____

List any substance abuse treatment or inpatient psychiatric treatment with approximate dates:

_____

_____

_____

Is there any other information you'd like us to know, which may help us in working with you?

_____

_____

Please indicate which substances you currently use:

Substance	Amount used	How often?	I'm concerned about my use
❑Cigarettes/nicotine			
❑Alcohol			
❑Marijuana			
❑Opiates			
❑Stimulants			
❑Others (please list):			

Check all that apply, either currently or in the past:

	Currently	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	❑	❑
Thoughts of harming other people	❑	❑
Problems concentrating	❑	❑
Periods of daily sadness lasting more than two weeks	❑	❑
Little or no interest in sex	❑	❑
Feel tired almost every day	❑	❑
Problems remembering things	❑	❑
Excessive hyperactivity or impulsive actions	❑	❑
Startle easily	❑	❑
Can't stop remembering upsetting past events	❑	❑
Difficulty controlling my temper	❑	❑
Physically hurt other people	❑	❑
Break things sometimes	❑	❑
Worry too much	❑	❑
Panic or anxiety attacks	❑	❑
Feel that I or my surroundings are unreal	❑	❑
Self-induced vomiting to lose weight	❑	❑
Use of laxatives or excessive exercise to lose weight	❑	❑
Often feel like I am an outsider	❑	❑
Sexual or gender concerns	❑	❑
Worry that something is wrong with my body	❑	❑
Relationship difficulties	❑	❑
Frequent arguments with the people I live with	❑	❑
Abusive relationships	❑	❑
Other (please list):		

Reviewed by _____ Date _____