

Horizon Therapy Group, LLC
300 West Broadway Suite 270
Council Bluffs, Iowa 51503
Phone: (712) 256-7511 Fax: (712) 256-9766

DATE: _____

REFERRED by: _____

CLIENT INFORMATION

Name: _____ Male _____ Female _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Social Security #: _____

Cell Phone: _____ Date of Birth: _____ Age: _____

In Case of an Emergency, whom may we contact on your behalf? _____

Relationship to you: _____ Address: _____

Phone: _____ Alternative Phone: _____

EMPLOYMENT & EDUCATION

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

Elementary/High School: _____ Grade/Graduation Date: _____

College/Technical Program: _____ Year/Graduation Date: _____

Military Branch: _____

CONTACT INFORMATION

May we leave messages with you? (check) Home: _____ Work: _____ Cell: _____

Email Address: _____

MARITAL STATUS

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Living with _____

Spouse or Domestic Partner's Name: _____

Employer: _____ Occupation: _____ Work Phone: _____

IF CLIENT IS A CHILD—COMPLETE THE FOLLOWING:

Child Lives With

Both Parents: _____ Mother: _____ Father: _____ Other (specify): _____

Father's Name: _____ **Mother's Name:** _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Employer Address _____ Employer Address _____

Employer Phone _____ Employer Phone _____

If deceased, cause of death _____ **If deceased, cause of death** _____

Client Name: _____

Date of Birth: _____

INSURANCE INFORMATION (Please refer to your insurance card/document)

PRIMARY INSURANCE

Name of Insured: _____
Relationship to Client _____
Insured's Date of Birth _____
Social Security # _____
Employer _____
Insurance Company _____
Group Plan # _____
Employee/cert. # _____

ADDITIONAL INSURANCE

Name of Insured: _____
Relationship to Client _____
Insured's Date of Birth _____
Social Security # _____
Employer _____
Insurance Company _____
Group Plan # _____
Employee/cert. # _____

AUTHORIZATION of Insurance Company Payment & Communication

I authorize the release of confidential information including professional opinions, reports of tests, exams, treatment summaries, diagnosis and prognosis rendered to me or my dependent during the period of such care, to third party payers. I authorize and request my insurance company to pay directly for all insurance benefits otherwise payable to me. I agree to be responsible for payment (charges which are considered usual and customary) of all services rendered on my behalf or on behalf of my dependents.

Signature of Client / Guardian of Client _____ **Date** _____

CONSENT to Evaluation & Treatment

I hereby give my legal and informed consent for me or my dependent child to be evaluated and treated by representatives of Horizon Therapy Group, LLC.

Signature _____ **Date** _____

CONSENT to Communicate With Primary Care Physician

PRIMARY CARE PHYSICIAN

Name of Doctor _____ Clinic Name _____
Address _____ Phone _____

In order to coordinate your care, we may need to contact your Primary Physician:

I hereby give my consent to such communication with my Primary Care Physician.

Signature _____ **Date** _____

I do **not** give my consent.

Signature _____ **Date** _____

HORIZON THERAPY GROUP, LLC

Medical Information

Name _____ Soc. Sec. # _____ Date _____

The reason I am here today is: _____

Please check the items below which apply to you in the past six months:

- | | |
|------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> change in appetite | <input type="checkbox"/> worried about your appearance |
| <input type="checkbox"/> loss of weight | <input type="checkbox"/> forgetfulness or memory problems |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> anger |
| <input type="checkbox"/> binge or purge | <input type="checkbox"/> verbal fighting |
| <input type="checkbox"/> worried about your weight | <input type="checkbox"/> physical fighting |
| <input type="checkbox"/> trouble sleeping | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> high energy | <input type="checkbox"/> difficulty concentrating |
| <input type="checkbox"/> low energy | <input type="checkbox"/> racing thoughts |
| <input type="checkbox"/> restless/difficulty sitting still | <input type="checkbox"/> sad or depressed |
| <input type="checkbox"/> anxious or nervous | <input type="checkbox"/> crying spells |
| <input type="checkbox"/> loss of interests | <input type="checkbox"/> thoughts of suicide |
| <input type="checkbox"/> feel like mind playing tricks | <input type="checkbox"/> self hurt/harm |

Have you ever had counseling/therapy or medication for any of the above? _____ Yes _____ No

If "Yes," where _____ when _____ with whom _____

Have you been hospitalized for any of the above? _____ No. If "Yes," reason _____

If "Yes," where _____ when _____ what Doctor _____

When did you last have a complete physical exam? _____

Who is your Primary Physician? _____

How do you rate your overall health? _____ Excellent _____ Good _____ Fair _____ Poor

What is your main concern about your health? _____

Any other medical problems? Please describe _____

Do you have any **Allergies or Drug Sensitivities**? If "Yes," describe: _____

Please complete the following regarding your current medication:

Name of Medication/Herbs	Prescription Yes/No	When Prescribed	Amount Daily	Reason

Do you Gamble? _____ Yes _____ No

How many times per month? _____

What percent of your monthly income do you spend per month on gambling? _____

Do you use Tobacco? _____ Yes _____ No

Do you use Caffeine _____ Yes _____ No

Please complete the following regarding your current and past alcohol & drug use/abuse:

TYPE	Currently using	Used in the past	Never used
Marijuana			
Methamphetamines			
Other illegal drugs			
Abuse of prescription drugs			
Abuse of over-the-counter medication			

Do you drink **Alcohol**? _____ Yes _____ No _____ Used in the past
 How many times per week? _____
 On an average, how many drinks per time? _____

Have you ever:

Yes No

	Yes	No
Thought you should cut down on your drinking or drug use?		
Been annoyed when others have asked you about your drinking or drug use?		
Felt guilty about how much you drink or used illegal drugs?		
Had a drink/used to get going or to treat a hangover?		
Had anyone complain about your drinking/using?		
Gotten in trouble with the law, family members, or friends when you drink/use?		
Do you usually get into trouble when you drink/use?		

Please check the items below which describe medical symptoms you have had in the past 12 months:

- | | |
|--------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> abnormal heartbeat | <input type="checkbox"/> balance problems/falling |
| <input type="checkbox"/> severe/persistent headaches | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> seizures | <input type="checkbox"/> numbness or weakness of limbs/body |
| <input type="checkbox"/> muscle weakness | <input type="checkbox"/> muscle pain |
| <input type="checkbox"/> Joint aches/pains | <input type="checkbox"/> bruise easily |
| <input type="checkbox"/> kidney infection/disease | <input type="checkbox"/> trouble urinating |
| <input type="checkbox"/> Urinary infection | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> stomach/abdominal pain | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> change in vision/trouble with eyes | <input type="checkbox"/> change in hearing/trouble with ears |
| <input type="checkbox"/> change in sense of smell | <input type="checkbox"/> feeling clumsy or dropping things |
| <input type="checkbox"/> pain in mouth or trouble swallowing | <input type="checkbox"/> sore/swollen neck/glands |
| <input type="checkbox"/> speech problem | <input type="checkbox"/> voice problems |
| <input type="checkbox"/> thyroid disease | <input type="checkbox"/> pain/lumps/drainage from breasts |

Client / Parent or Guardian of Client Signature : _____ **Date:** _____

Therapist's Signature _____ Date Reviewed _____

Referred for a physical Exam? Yes _____ No _____ If referred, to whom? _____
 Referred for a Psychiatric Evaluation? Yes _____ No _____ If referred, to whom? _____
 Client willing to accept referral? Yes _____ No _____

Next appointment scheduled for the client on: _____

Horizon Therapy Group, LLC

Client Name: _____ **Date of Birth:** _____

New Client Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Horizon Therapy Group, LLC originates and maintains paper and/or electronic records describing my health ^{Rev. 7/2012} examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Horizon Therapy Group, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Horizon Therapy Group, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Horizon Therapy Group, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

- I fully understand and (**Accept or Decline**) the terms of this consent.
(Circle One)

Client's Signature _____ **Date:** _____

Horizon Therapy Group, LLC

Client Name: _____ **Date of Birth:** _____

CLIENT BILL OF RIGHTS

You have the right to:

- Receive respectful treatment that will be helpful to you.
- Have a safe environment, free from sexual, physical, and emotional abuse.
- Report unethical and illegal behavior by a therapist.
- Request and receive information about the therapist's professional capabilities, including licensure, education, training, experience, membership in professional associations, specialized areas of practice, and limitations on practice.
- Have written information, before entering therapy, about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacations and emergencies), and cancellation policies.
- Refuse electronic recording, but you may request it if you wish.
- Refuse to answer any questions or disclose any information you choose not to reveal.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Request that the therapist inform you of your progress.

_____ **Date** _____
Client's Signature

Horizon Therapy Group, LLC
300 W. Broadway, Suite 270
Council Bluffs, Iowa 51503
Phone (712) 256-7511 Fax (712) 256-9766

Client Name: _____ **Date of Birth:** _____

Welcome!

We are committed to providing you with excellent service. In order for our work together to be productive, it is important that expectations be clearly defined.

What you can expect from us:

- The information you share with us will be kept confidential.
- To notify you as soon as possible if your provider has to cancel your appointment and to make arrangements with you to reschedule.
- To make every effort to be on time and to return your phone calls.
- To work with you to set achievable goals and assist you in making progress towards these goals.

What we expect from you:

- To be involved in setting your goals for therapy and to make progress.
- To attend scheduled appointments or call 24 hours in advance to cancel.
- To take financial responsibility by pre-authorizing treatment with your insurance company, paying co-pays at time of service, and keeping your account current.

Fees:

Evaluations: Therapist--\$200 Nurse Practitioner--\$300
Therapy Sessions: Therapist--\$130 Medication Checks: Medication Checks--\$125 to \$300
No Show/Late Cancel Appointments: \$50 _____ **Client/Guardian's initials**

Insurance:

If you are using health insurance, you will need to verify coverage prior to your first visit. If your insurance company will cover our services, and if I am a provider for your insurance company, our office will bill your company after each visit. If your coverage is contracted with your HMO or PPO, you are only responsible for the required co-payment. Co-payments are due before each session. If you do not have coverage, full payment is expected on the day of your session.

County Program:

Residents of Pottawattamie County or surrounding select counties, who are without health insurance, may complete paperwork to apply for a sliding fee. Paperwork must be completed on the day of your first appointment, and you must qualify for the program by proving financial need.

In case of an emergency: We have a 24 hour service available by calling (712) 256-7511, and the on-call staff will do their best to assist you.

I understand that by not showing up for two scheduled appointments, I forfeit the right to remain a client of Horizon Therapy Group. I have read the above information and my signature indicates my acceptance of the terms of this agreement.

Provider for Horizon Therapy Group
(Rev:6/2014)

Client or Parent/Guardian Date

Horizon Therapy Group, LLC
300 W. Broadway Suite 270, Council Bluffs, IA 51503
Phone: (712) 256-7511 ~ Fax: (712) 256-9766

Consent To Release Confidential Information
(Please release only the information requested)

Patient Name: _____

Patient Address: _____

Patient Birth Date: _____

I hereby authorize and direct that:

___ Horizon Therapy Group, LLC will send information to:

___ Horizon Therapy Group, LLC will receive information from:

I understand that the type of information includes and is limited to the following specific information:

- | | |
|-----------------------------------|------------------------------------|
| ___ Medical: Discharge Summary | ___ Psychiatric Evaluation |
| ___ Medical: History and Physical | ___ Psychological Evaluation |
| ___ Social History | ___ Chemical Dependency Evaluation |
| ___ Progress Notes | ___ Verbal Information |
| ___ Letters | |
| ___ Other (Please Specify) _____ | |

The information requested and disclosure of information is being made for the following purpose(s):

Dates of service for which the disclosure of information is being made: _____ to _____

I understand that information released may include reports of drug or alcohol abuse or psychiatric care and that this information will not be released to any other agency, individual or organization for any other purpose without my written consent except as required by Federal or State law.

I understand that I may revoke this consent at any time by sending written notice to Horizon Therapy Group, LLC. If I do so, I know that it cannot apply to any information that had been released before receipt of my written notice. In any case, this consent will expire one year from the date of my signature to this form, unless otherwise specified.

Client or Parent/Guardian: _____ **Date:** _____

Witness: _____

**Horizon Therapy Group
300 West Broadway, Suite 270
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Phone: (712) 256-7511 & FAX: (712) 256-9766**

Psychiatric Advance Directive

Client Name: _____ **DOB:** _____

_____ I currently have a Psychiatric Advance Directive.

_____ I do not have a Psychiatric Advance Directive. I understand that I can follow-up on this with the information provided below. If such a document is completed, I will provide a copy to this agency.

Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

What can be included in a Psychiatric Advance Directive

- Crisis Symptoms
- Medication Choices
- Hospital Choices
- Emergency Contacts
- Relapse/Protective Factors
- Instructions to Staff
- Other Instructions

For more information on what you can include in a Psychiatric Advance Directive, log on to www.nrc-pad.org

Attached is a sample of Iowa's Advanced Directive for Health Care Decisions. It is advised that you seek legal counsel when completing this document. Iowa currently does not have a specific Psychiatric Advance Directive Form.

Client/Parent of Client **Date**



300 W. Broadway, Ste 270, Council Bluffs, IA 51503
Phone (712) 256-7511 Fax 712-256-9766

Consent to Use of Electronic Communication and Patient Rights

CONDITIONS FOR USE OF Electronic Communication

Horizon Therapy Group, LLC will use reasonable means to maintain security and confidentiality of electronic communication information sent and received. Please acknowledge and consent to the following conditions:

1. Electronic communication may include, but is not limited to, email, text messaging, facsimile, social media, etc.
2. Horizon Therapy Group, LLC will work with you to avoid disadvantages (such as too much risk to your privacy or using electronic communication) when a face-to-face visit appears to be necessary. It is also important to understand that at times, email communication or cell phone communication including text message content between you and your therapist may be misinterpreted due to lack of eye contact, vocal tone, and attending to facial expressions between client and therapist. If you are unsure about the intent or content of an email or the intent of the therapist via cell message or conversation, you are encouraged to discuss concerns/questions and ask for clarification.
3. Electronic communication is not appropriate for urgent or emergency situations. We will do our best to respond within 3 working days. If you have not received a response after 3 days, please call to speak directly with us at (712) 256-7511. If you're experiencing an emergency, call 911 or your local emergency room.
4. Electronic communication should not be used for communication regarding sensitive or life-threatening subjects, such as suicidality, spouse or child abuse, chemical dependency, etc.
5. Electronic communication related to health consultation may be recorded in your medical record, just as telephone calls and sessions are.
6. If you frequently contact your therapist via email or phone outside of your normal session, it is important to understand that your therapist will bill you for a portion of his or her time, based on his or her regular hourly rate as agreed upon. As the therapist sees numerous clients per week, the therapist may receive numerous emails and calls each week from many clients.
7. To protect your privacy, please understand that it is against Horizon Therapy Group, LLC professional ethics to link with clients through any social media platform (ex. Facebook, Twitter, Instagram, etc.).

RISKS OF USING Electronic Communication

Transmitting information by electronic communication has risks to consider. These include, but are not limited to, the following:

1. Electronic communications can be altered, intercepted, forwarded or used without authorization or detection.
2. Electronic communications can be circulated, forwarded and stored in paper and electronic files.
3. Electronic communication senders can type in the wrong email address/phone number.
4. Electronic communications may be lost due to technical failure during composition, transmission and/or storage.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I have read and fully understand the information in this authorization form. I consent to the Electronic Communication conditions and agree to abide by the guidelines listed above, as well as understand and accept the risks associated with the use of unsecured Electronic Communications. I further understand that, as with all means of Electronic Communication, there may be instances beyond the control of the health care provider where information may be lost or inadvertently exposed, such as during technical failures. By signing below, I acknowledge the privacy risks associated with using Electronic Communications and authorize Horizon Therapy Group, LLC to communicate with me or any minor dependent/ward for purpose of mental health and/or substance use advice, education, and treatment.

Signature of Client _____ Date _____

Signature of Parent/Guardian
(if required) _____ Date _____

Signature of Therapist _____ Date _____

Consent for Electronic Session Recording

With the client's or parent/guardian's consent, it may be found beneficial for certain aspects of a therapy session to be tape recorded, videotaped, or photographed. The recordings will only be used for the following purposes: to retain important information in client files that can benefit the overall treatment plan in future sessions or to allow students who are coming into the mental health field to gain insight and further their education. The use of this technique is entirely up to the client or parent/guardian and can be amended at any time.

Client or Guardian Signature _____ Date _____