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) At Home:____ At Work:____ Email:_____
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):_____

Parent/Guardian:	**Parent/Guardian:**
Date of Birth	Date of Birth
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	**SECONDARY INSURANCE**
Name of Insured:_____	Name of Insured:_____
Relationship to Client_____	Relationship to Client_____
Insured's Date of Birth_____	Insured's Date of Birth_____
Social Security #_____	Social Security #_____
Employer_____	Employer_____
Insurance Company_____	Insurance Company_____
ID #_____	Group Plan #_____

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_____Date_____

CONSENT to Evaluation, Treatment and Appointment Reminders

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. I authorize Horizon Therapy Group to use my personal contact information to remind me of appointments.

Signature of Client/Guardian_____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 PrimaryPhysician:

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_____ Date of Birth_____

The reason I am here today is:_____

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

____change in appetite
____loss of weight
____weight gain
____binge or purge on food
____worried about your weight
____trouble sleeping
____high energy
____low energy
____restless/difficulty sitting still
____anxious or nervous
____loss of interests
____feel like mind playing tricks
____sexual identity concerns
____mood shifts
____paranoia
____worried about your appearance
____forgetfulness or memory problems
____anger
____verbal fighting
____physical fighting
____sexual problems
____difficulty concentrating
____racing thoughts
____sad or depressed
____crying spells
____thoughts of suicide
____self hurt/harm
____gender concerns
____irritability

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**
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:

_____Persistent cough
_____heart disease
_____abnormal heartbeat
_____severe/persistent headaches
_____seizures
_____muscle weakness
_____Joint aches/pains
_____kidney infection/disease
_____Urinary infection
_____stomach/abdominal pain
_____change in vision/trouble with eyes
_____change in sense of smell
_____pain in mouth or trouble swallowing
_____speech problem
_____thyroid disease
_____shortness of breath
_____high blood pressure
_____balance problems/falling
_____Loss of consciousness
_____numbness or weakness of limbs/body
_____muscle pain
_____bruise easily
_____trouble urinating
_____liver disease
_____vomiting
_____change in hearing/trouble with ears
_____feeling clumsy or dropping things
_____sore/swollen neck/glands
_____voice problems
_____pain/lumps/drainage from breasts

Signature of Client/Guardian_____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 history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as: Rev. 7/2012

- 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 received 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

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.
- Be responsible for the cost of no shows and late cancellations.

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.

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 have read the above information and my signature indicates my acceptance of the terms of this agreement.

_____ _____

Provider for Horizon Therapy Group **Client/Guardian Signature** **Date**

(Rev: 8/2017)

Horizon Therapy Group
300 West Broadway, Suite 270
Council Bluffs, Iowa 51503
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_____