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	**ADDITIONAL 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_____
Group Plan #_____	Group Plan #_____
Employee/cert. #_____	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 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_____**Soc. Sec. #**_____**Date**_____

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
____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
____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

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

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 history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care Rev. 7/2012
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 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.

Fees:

Evaluations: Therapist--$200 Nurse Practitioner--$300
Therapy Sessions: Therapist--$130 Medication Checks: 15 Minute Check--$125
Medication Check with Therapy--$90
No Show/Late Cancel Appointments: $50 _____**Client'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.

Sliding Fee:

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

_____ _____

Provider for Horizon Therapy Group **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
___ Medical: History and Physical
___ Social History
___ Progress Notes
___ Letters
___ Other (Please Specify) _____
___ Psychiatric Evaluation
___ Psychological Evaluation
___ Chemical Dependency Evaluation
___ Verbal Information

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:_____

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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**

TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I _____ [name of patient] consent to engaging in telehealth psychotherapy with Horizon Therapy Group, LLC. I understand that "telehealth psychotherapy" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in the state of Iowa. I understand that I may need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good connection at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Horizon Therapy Group, LLC via phone to coordinate alternative methods of treatment.

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card only, due at time of session. I agree to have my card information on file with Horizon Therapy Group, LLC. If my card is declined, my therapist will cancel all appointments and I will be charged in accordance with the existing policy. I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Horizon Therapy Group release of any required information to my insurance provider to process claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the Horizon Therapy Group, LLC cancellation policy as documented by my signature on the Informed Consent. (Client Initial: _____)

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted through Horizon Therapy Group, LLC and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services.

Video/Audio Recording: As a general practice Horizon Therapy Group, LLC DOES NOT record Telemedicine sessions without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telehealth, as outlined in the existing Informed Consent. I acknowledge that I have read and signed this form, with the understanding of my rights. Horizon Therapy Group, LLC's Telemedicine platform is HIPAA compliant to protect my privacy and confidentiality. I understand I have the right to withdraw my consent at any time. I understand associated risks with telehealth, including: transmission of information (despite best practice efforts), variance in quality of services/results, and changes in accessibility due to my location. I understand that Horizon Therapy Group, LLC will provide telehealth services within the state of Iowa only. I have read and understand the information provided above. I have discussed it with my therapist, and all questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

_____	_____	_____
Client's Signature & Date	Guardian's Signature & Date	Therapist's Signature & Date