

Date: _____

New Horizon Counseling Center

Personal Identification

Name: _____ Sex: M / F

Nickname: _____ Date of Birth: _____ Age: _____

Address: _____
Street City State Zip

Marital Status(please circle one): Single / Cohabiting / Engaged / Married / Divorced / Separated / Widowed

Education (last year completed): _____ School: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Number: _____

Emergency Contact's Relationship to Client: Parent / Spouse / Child / Sibling / Other: _____

As part of the HIPAA Privacy Rule, please tell us how you wish for us to communicate with you:

Home# _____ Cell# _____

Work # _____ Email: _____

May we leave a message with details of appointments and/or billing issues: Y / N If no, we will only leave a call back number.

Would you like to receive appointment reminders? Y / N If yes, please state below how you would like to receive them.

Phone Call: _____ Text: _____ Email: _____

Person/ Organization who referred you: _____

Insurance Information

Name of Insured: _____ Insured Birth Date: _____

Insured's relationship to Client (please circle one): Self / Spouse / Child / Parent / Other: _____

Insured Address: _____
Street City State Zip

Insured Employer: _____ Insurance Company: _____

Insured Home#: _____ Insured Cell#: _____

PERSONAL DATA INVENTORY

(PLEASE COMPLETE THIS FORM CAREFULLY)

Marriage and Family

Spouse's Name: _____ Date of Birth: _____

Present Employer: _____ Home# _____ Cell# _____ Work# _____

Years Married _____ Previous Marriages: Y / N How did the marriage(s) end? _____

Children's Names	Age	Sex (M/F)	Living? (Y/N)	Birth Parent? (Y/N)

Briefly describe your childhood _____

Number of siblings: _____ Number of siblings living: _____ Mother: Living / Deceased Father: Living / Deceased

Your Birth Order: Only Child / Oldest / Middle / Youngest / Other _____

Physical Health

Describe your health: Excellent / Good / Fair / Poor Do you have any chronic conditions? Y / N

If yes, what are they? _____

Please provide the following information regarding prescriptions you are presently taking:

Name: _____ For: _____ Dose: _____ Times per Day: _____

Name: _____ For: _____ Dose: _____ Times per Day: _____

Name: _____ For: _____ Dose: _____ Times per Day: _____

Have you ever used drugs for other than medical purposes? Y / N If yes, please explain: _____

Date of your last physical exam:(MM/YY) _____ Results: _____

List any important illness, injuries and/or handicaps/surgeries: _____

Is there a history of alcoholism in your family? Y / N

Do you drink alcoholic beverages? Y / N How much/ How often? _____

Do you smoke?Y / N How much/ How often? _____

Mental and Emotional Health

What brings you here today? _____

Client Financial Agreement and Payment Information

Insurance

New Horizon Counseling Center (NHCC) accepts many different insurance plans including EAP (Employee Assistance Program). EAP sessions are covered at 100% by participating employers for an authorized number of sessions. Some health insurance carriers require the patient to pay a co-pay or co-insurance, depending on the patient's plan. There is no guarantee that services will be covered. Our office can estimate what you will owe; actual out-of-pocket expense may be more or less than the estimated amount. Patient will be billed or credited the difference.

I hereby authorize the release of any and all protected health information NHCC may need to process payment for services received. I also hereby authorize any insurance company payments to be made directly to New Horizon Counseling Center. NHCC will only communicate the patient's protected health information according to the terms of our Privacy Rule.

Client Signature: _____ Date: _____

Payment Agreement

If I am not currently insured, or my insurance does not cover and/or pay for services, I understand that I have sole responsibility, and agree to pay, for all services received. A sliding scale fee/reduced fee is offered upon request depending on your financial situation. The fee is \$90 per 50 minute session. Sessions longer than 50 minutes will be billed an additional \$15 per 15 minutes. First time visits (evaluations/assessments) are \$100. Payments are to be made directly to New Horizon Counseling Center and are required at time of appointment. NHCC accepts cash, checks, credit cards, and HSA (Health Savings Account) cards.

I understand I am responsible for any collection of payment amounts incurred including third-party collection efforts and attorney fees.

Client Signature: _____ Date: _____

Returned Checks/Cancellation Fees

There is a returned check fee of \$15 for bounced/canceled checks.

If a conflict arises and an appointment must be cancelled or rescheduled, 24 hours' notice is required to avoid being billed for the cancelled appointment in the amount of \$50.00. Fee may be waived in the event of an emergency or illness.

I understand the financial policy of New Horizon Counseling Center and agree to them.

Client Signature: _____ Date: _____

HIPAA/Privacy Rule Notice

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule was instituted by the Department of Health and Human Services (hereafter, DHHS) in order to protect consumers of healthcare, providers of healthcare and healthcare networks. This law requires that healthcare providers comply with certain procedures regarding the health information of a client. In short, the HIPAA privacy rule regulates the circumstances and conditions under which a “covered entity” may use or disclose “protected health information” (PHI). (45 C.F.R. Parts 160, 164)

Protected Health Information (PHI) is any information which identifies a person and discloses information about his physical or mental health, healthcare provided to him or payment for said healthcare.

A **Covered Entity** is defined as a health plan, a health care provider who bills insurance carriers for services rendered, or a health care clearing house that processes health insurance claim forms for payment to providers.

New Horizon Counseling Center follows the Code of Ethics published by the National Association of Social Workers (A copy of this document is available for review from the Privacy Officer) which states that we shall maintain client confidentiality to the fullest extent allowed by law. Therefore, New Horizon Counseling demonstrates a good faith effort toward following HIPAA regulations.

Under the Privacy Rule, the permitted uses and disclosures are:

- To the client
- For treatment
- As authorized

Additional uses and disclosures include those related to:

- Reporting on victims of domestic violence or abuse, as required by law
- Court orders
- Workers' compensation laws
- Serious threats to health or safety
- Government oversight

The therapist will abide by the Privacy Rule as well as state and federal laws governing PHI. In addition, the therapist will meet the “minimum necessary requirement”.

Minimum Necessary Requirement

When disclosing information, the therapist will make a reasonable effort to limit PHI to only that information which is necessary to fulfill the purpose of the use, request, or disclosure.

The minimum necessary requirement does NOT apply to the following situations:

- Disclosures for treatment purposes
- Information sharing between therapists and client
- Disclosures when client authorization is given
- Disclosures required by law or for compliance with Privacy Rule

In order to ensure compliance with the minimum necessary requirement, an authorization to release information must be signed by the client. The therapist will provide the authorization form. A copy of the release form will be kept in the client record and a copy is available at the client's request. In addition, the therapist will go over any information to be released prior to the actual release. The therapist will not use an entire clinical record except when justified to accomplish the purpose of the use, request, or disclosure. New Horizon Counseling Center makes every effort to ensure that PHI is kept safely and securely, with a minimal number of staff having access to that information. In our offices, the client's PHI will be available to the client's therapist, our secretarial staff, and to the supervising therapist.

I have been given a copy of this form and an opportunity to read and ask questions about this document.

Client Signature _____ Date _____

Witness Signature _____ Date _____