New Horizon Counseling Center

Personal Data Entry

Child/Adolescent

Personal Identification

Name of Child/Adolescent ____ D.O.B ___________________________

Age ____________Sex ___________ Home#____________________________________ Cell# _____________________________________

Address ____

. Street City State Zip

School Attending ____ Grade __________ School # __________________________________

Person/Organization who referred you to us____

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

Home# ________________________________ Work #______________________________ Cell# __________________________________

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

Other means of communication (fax, txt, etc.) ____

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: _______________________________________

Insurance Information

Name of Insured: ____ Insured Birth Date: _______________________

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#: ____

Marriage and Family

Parent(s) Name(s) ____

Marital Status (Circle one): Single / Cohabitating / Engaged / Married / Separated / Divorced / Widowed

Mom's Home# ________________________________ Work#_______________________________ Cell#_____________________________

Present Employer ____ Position ____

Dad's Home#_________________________________ Work#_______________________________ Cell#_____________________________

Present Employer ____ Position ____

Custodial Parent ____

Siblings' Names	Age	Sex (M/F)

Client's Birth Order: Only Child / Oldest / Middle / Youngest / Other ______________________________

Child/Adolescent's Characteristics

Please indicate below any qualities or concerns that presently exist or may be contributing to your child/adolescent's present circumstance: **Please circle any concern(s) applicable**.

Developmental Delays	Academics	Sleep	Friendships	Suicidal Thoughts/Ideas
Anger	Envy	Appetite	Health	Emotional Behavior
Spiritual	Anxiety	Fear	Toilet Training	Family Member(s)
Substance Abuse	Social Behavior	Lying	Rebellion	Harm to Others/Animals
Impulse Control	Divorce	Sexuality	Moodiness	Deception
Physical Difficulties	Bitterness	Guilt	School	Trust
Siblings	Attention Span	Change in Lifestyle	Activity Level	Depression

Family History of: ______________________________ Other: ______________________________

____

Abuse (Circle all that apply): Childhood / Physical / Sexual / Verbal / Emotional / Spiritual

Health

Please provide the following information regarding prescriptions the child/adolescent is presently taking:

Name ______________ For ______________ Dose ______________ Times per Day ________

Name ______________ For ______________ Dose ______________ Times per Day ________

Name ______________ For ______________ Dose ______________ Times per Day ________

Date of child/adolescent's last physical exam: ____________ Results: ______________________________

____

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

____

Past Psychiatrist/Counselor Names | Dates of Service

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Family History

Is there a family history of:

Health problems?Y / N If yes, what are they? ____

____

Depression or thoughts of suicide?Y / N Date: _________________ Incident: ____

____

Date: _________________ Incident: ____

____

Substance abuse?Y / N If yes, what are the circumstances? ____

____

Marital difficulties/Divorce?Y / N If yes, what are the circumstances? ____

____

Financial difficulties?Y / N If yes, what are the circumstances?____

Behavioral difficulties with other children in the family?Y / N If yes, what are the circumstances?_______________________________________

____

Other sources of stress?Y / N If yes, what are they? ____

____

Spiritual

What importance does your faith, belief, or spirituality have to the client/client's family? ____

____

Are you a part of a spiritual or religious community? How important is this to the client/client's family? ___________________________________

____

May the counselor discuss these topics with your child/adolescent? Y / N

New Horizon Counseling Center offers psychotherapeutic services. The therapy relationship is both professional and confidential. What is revealed in this setting is protected by legal, professional and ethical standards, such that, with a few important exceptions; all material is confidential and not released without your written consent. Ethically and legally, however, if there is a reasonable possibility of your harming others or yourself, the therapist is responsible to inform others in order to protect them or you. If there is a reasonable possibility of child abuse, or evidence of elder abuse, this must be reported immediately to the proper protective service. There is no statute of limitations for abuse cases so, conceivably a report on past abuse might be required in order to assure a child or elder's protection. Depending on the circumstances, a report could result in an investigation by authorities to determine if legal action is warranted. We believe in a holistic approach to counseling, but not mandated. We are committed to protecting the privacy of the client within the perimeters of the therapeutic relationship. New Horizon Counseling team meet weekly for supervision to assure that the client is receiving the best counsel provided.

I have read the above and understand that the therapy relationship is a private and confidential one with the exceptions noted above. I agree to meet my financial obligation for each session.

Parent Signature ____ Date ______________________________

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.

Parent 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.

Parent 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.

Parent Signature: ____ Date: _______________________

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 the3 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.

Parent Signature ____ Date ________________________________

Witness Signature ____ Date ________________________________