New Horizon Counseling Center

Date: _____

Name of Child/Adolescent: _____Preferred Name: _____

DOB: _____ Age: _____Sex: _____ Race: _____SSN:_____

Address _____
Street City State Zip

School Attending _____ Grade _____

Parent(s) Name(s) _____Custodial Parent_____

Marital Status of Parents (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 _____

Which number may we leave a confidential message? ☐ Home ☐ Cell ☐ Work ☐ Other: _____

Would you like to receive appointment reminders? ☐ Yes ☐ No

Person/Organization who referred you to us_____

Insurance Information

Name of Insured: _____ Insured Birth Date: _____

Relationship to Client (please circle one): Self / Parent / Other

Insured Address: _____
Street City State Zip

Insured Employer: _____ Insurance Company: _____

Insured Home#: _____ Insured Cell#: _____

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 _____

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: _____

Primary Physician: _____ Phone: _____

List any important illness, injuries, allergies, handicaps, or surgeries: _____

_____

Past Psychiatrist/Psychologist/Counselor Names	Dates of Service (MM/YY - MM/YY)
_____	_____
_____	_____

New Horizon Counseling Center

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

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

Family History

Is there a family history of:

Health problems? Yes /No If yes, what are they? _____

Depression or thoughts of suicide? Yes /No Date: _____ Incident: _____

_____

Substance abuse? Yes /No If yes, what are the circumstances? _____

_____

Marital difficulties/Divorce? Yes /No If yes, what are the circumstances? _____

_____

Financial difficulties? Yes /No If yes, what are the circumstances?_____

Behavioral difficulties with other children in the family? Yes /No If yes, what are the circumstances?_____

_____

Other sources of stress? Yes /No If yes, what are they? _____

_____

Siblings' Names	Age	Sex (M/F)	Living? Yes/No

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

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

Consent to Participation

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 and/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. New Horizon Therapeutic team (counseling center only) meet weekly for the supervision where cases are discussed to assure that the client is receiving the best counsel that we can provide. We are committed to protecting the privacy of the client.

I have read the above and understand that the therapy relationship is a private and confidential one with the exceptions noted above.

Parent Signature _____ Date _____

Financial Policy

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. NHCC may give an estimate of what your out-of-pocket expense might be, but it is the client's responsibility to know their plan benefits. There is no guarantee that services will be covered by your insurance.

First time visits (evaluations/assessments) are $100. The fee is $90 per 50-60 minute session. Sessions longer than 60 minutes will be billed an additional $15 per 15 minutes. Payments are to be made directly to New Horizon Counseling Center and are required at time of appointment. A sliding scale fee/reduced fee is offered upon request depending on your financial situation. NHCC accepts cash, checks, credit cards, and HSA (Health Savings Account) cards.

There is a returned check fee of $15 per bounced/canceled check, and a late fee of $5 per month on account balances that are not paid (unless other arrangements have been made with our billing department).

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.

Financial Agreement

If I am currently uninsured, or my insurance does not cover and/or pay for these services, I understand that I have sole responsibility, and agree to pay, for all services received. I also understand I am responsible for any collection of payment amounts incurred, including third-party collection efforts and attorney fees.

I understand the Financial Policy of New Horizon Counseling Center and agree to them.

Parent Signature: _____ Date: _____

New Horizon Counseling Center
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 read and understand this document. I know I can ask questions and request a copy of this document.

Parent Signature _____ Date _____

Witness Signature _____ Date _____