Intake Form

Patient Name: _____ DOB: _____ M F

Policy Holder: _____ DOB: _____ M F

Patient SSN: _____

Policy Holder SSN: _____

Address: _____

Primary Phone: _____ Cell Home Work

Messages OK? YES NO

Alternate Phone: _____ Cell Home Work

Messages OK? YES NO

Insurance Information

Primary Insurance: _____

Check if: Active Duty Military _____ Retired Military _____ Military Dependent _____

Group #: _____ Policy #: _____

Insured Employer: _____

Secondary Insurance: _____

Group #: _____ Policy #: _____

Insured Employer: _____

Notice of Privacy Practices

This notice describes how Protected Health Information (PHI) for Angels on the Horizon Therapeutic Center, LLC clients can be used and disclosed, client rights to access and ament their information, and grievance procedures. The following policies and procedures are based on Privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable Texas State Law. Please review it carefully.

- Angels on the Horizon Therapeutic Center, LLC is permitted to use and disclose protected health information (PHI) for treatment, payment and health care operations, as described in the following examples:
  1. For treatment – example: information about you may be used to provide treatment and services.
  2. For payment – example: determining a client's insurance eligibility or coverage, obtaining prior authorization from an insurance company for a service, or billing a client's insurance for a service provided.
  3. For health care operations – example: outcomes evaluations or quality assessment activities.

- Angels on the Horizon Therapeutic Center, LLC may contact individuals for appointment reminders.

- Angels on the Horizon Therapeutic Center, LLC is permitted or required, under specific circumstances, to use or disclose protected health information without written authorization from the individual. If use or disclosure for any purpose as prescribed by the Privacy Regulation is prohibited or materially limited by applicable Texas State law, the most stringent law's description of the use or disclosure is applied.

- Other uses and disclosures will be made only with the individual's written authorization and the individual may revoke such authorization.

Without your written request and authorization, Angels on the Horizon Therapeutic Center, LLC does not disclose information to insurance or other payers for services that you choose to pay for yourself out-of-pocket.

- Angels on the Horizon Therapeutic Center, LLC is obligated to report to you any breach of your PHI which compromise your privacy within 30 days of learning of the breach.

Client Rights

Individuals have the following rights regarding protected health information; the extent of and exceptions of these rights in the Privacy Regulation:

1. The right to request restrictions on certain uses and disclosures of protected health information. Angels on the Horizon Therapeutic Center, LLC is not, however, required to agree to requested restrictions.
2. The right to receive confidential communications of protected health information, as applicable.
3. The right to inspect and copy protected health information, as applicable.
4. The right to request amendment of your protected health information, as applicable.
5. The right to receive an accounting of disclosures of protected health information, as applicable.
6. The right to obtain a paper copy of the Notice from Angels on the Horizon Therapeutic Center, LLC upon request. This right extends to an individual who has agreed to receive the Notice electronically.

Federal and State laws grant clients of Angels on the Horizon Therapeutic Center, LLC the right of strict privacy in regard to information about themselves. This means that no information by which a client could be identified will be given by us to anyone else at any time without written consent of the individual, unless specifically required or permitted for treatment, payment or health care operations purposes by law, Important exceptions are that agency staff is required by law to report incidents or suspicions of harm to self or others, child abuse/neglect, and elderly or dependent abuse/neglect to the appropriate DFPS. I/We understand that staff is also legally compelled to testify in a court of law to disclose information if a judge deems that there is a just cause for such testimony and will release information to licensing broads as they are required. Staff is required by law to release records if they are subpoenaed in a court case.

Individuals are not required to give any information about themselves. However, refusal to give needed information will hamper service planning. The information that is requested about clients is needed for one or more of the following reasons:

1. To help us evaluate clients' needs for services and to develop a plan to meet those needs.
2. To determine financial eligibility for reduced service fees.
3. To meet Federal, State and Local statistical requirements.

- No audio or video recording of a treatment session will be made without client permission. NO one except agency staff involved in treatment will view or listen to a treatment session or a recording of a session, or read a verbatim transcript of a session unless the client gives permission.

- Individuals have the right to view their protected health information with the following exceptions:
  1. If a doctor or licensed provider believes that it will be harmful to the client or others.
  2. Information complied in anticipation of, or for use in, a civil, criminal or administrative action or proceeding.
  3. Information obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be likely to reveal the source of the information.

- Clients may have the information explained to them by an agency clinician/worker and may request corrections, additions, or amendments to any information in their client chart. If individuals have any questions about data privacy or client privacy rights, they may contact the agency's privacy official or their clinician/worker.

- Angels on the Horizon Therapeutic Center, LLC is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.

- Angels on the Horizon Therapeutic Center, LLC is required to abide by the terms of the Notice currently in effect.

- Angels on the Horizon Therapeutic Center, LLC reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.

- Angels on the Horizon Therapeutic Center, LLC will provide individuals with a copy of the revised Notice at the individual's next appointment. Clients may also access the revised Notice on the agency's website or request by phone that a copy be sent to them.

- If an individual believes that their privacy rights have been violated, complaints may be made to Angels on the Horizon Therapeutic Center, LLC and to the Secretary of the Department of Health and Human Services without fear of retaliation by the organization. A description of how a complaint may be filed as follows:

Client Grievance/Complaint Procedure

The staff of Angels on the Horizon Therapeutic Center, LLC strives to provide the highest quality of professional services. Any concern that a client has about the service and/or treatment associated with Angels on the Horizon Therapeutic Center, LLC staff and/or the facility may be communicated in writing, by phone, or in person. We encourage individuals to present their concern within a month of when the situation occurred.

It is the expectation of the agency that when a conflict or misunderstanding occurs, the client will make every effort to resolve the concern directly with the person involved. If those efforts do not resolve the disagreement the complaint can be taken to the supervisor or member of the management team for resolution, which may include facilitating a meeting of the persons involved in the disagreement.

Filing a Grievance

A formal grievance is an official statement over something believed to be wrong or unfair, or breaking a rule or law. The grievance will be in writing and submitted to a Partner of the agency.

All efforts will be made to obtain resolution to grievances in the shortest time possible with the goal being no more than 30 days. The timelines to achieve this may be effected by factors such as the availability of the person(s) involved. If there are unavoidable delays, the person making the complaint will be notified about the circumstances.

If you do not feel the grievance procedure has yielded satisfactory resolution and/or if you do not want to utilize this procedure, you may contact the State of Texas Department of Health and Human Services to register a grievance at 800-647-6558.

_____ _____

Name Date

Informed Consent

Process of Therapy

Intake policy and procedure:
The goals of the initial intake session are to complete a thorough client history and to gain information regarding the presenting issues. This is also a time to discuss the process of therapy and to answer any questions you may have. It is important to obtain informed consent before beginning the therapy process.

Scheduling:
If you choose to go forward in therapy, sessions will be set up which are generally 45-60 minutes in length. Approval for 60 minute sessions will need to be obtained by some insurance companies through prior authorization; additional fees may apply for 60 minute sessions. Frequency of sessions will be determined based on need.

Therapy Goals:
It is our procedure to work with you to identify therapeutic goals and to develop a treatment plan in the first two or three sessions. This plan provides a guide for therapy sessions and a basis for progress evaluation.

Therapy Process:
Therapy is an investment of your time and energy. It will be of most benefit if you are active in identifying issues and working together towards change. You will make your own decisions. The therapist's role is to act as a guide, teacher, co-learner and companion in the therapy process. A closure session is often helpful at the end of therapy to summarize the course and progress in your work and to give you recommendations for the future.

Your Rights as a Client
You are entitled to information about any procedures, methods of therapy, techniques, and possible duration of therapy.

You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. If you wish to see another therapist, the names of other qualified professionals whose services you might prefer can be provided.

You have the right to expect confidentiality. However, there are limitations to this right. I am required by mandatory reporting law to report: (a) if you threaten bodily harm to another person or yourself; (b) if you reveal information regarding the abuse or neglect of a child or vulnerable adult; (c) if a judge issues a signed court order; and (d) if you are in therapy by order of a court of law. Also, insurance companies require certain information in order to cover services. Parents have access to their children's records with certain expectations.

You have a professional relationship rather than a personal one with your therapist at Angels on the Horizon Therapeutic Center, LLC. In most instances, our contact will be limited to sessions at Angels on the Horizon Therapeutic Center, LLC. If you happen to see our staff in a public setting, all staff will respect your confidentiality and refrain from acknowledging or communicating with you in order to protect confidentiality. If you are comfortable and choose to acknowledge any Angels on the Horizon Therapeutic Center, LLC staff, the staff will follow your lead with regard to communication. Staff will not be offended if you choose not to acknowledge them in public.

At your written request, records can be released to any person or agency you designate once you have completed an authorization for release form. Also, you may authorize me to consult with another professional about your therapy.

You have the right to file a complaint with the appropriate state licensing Boards. If you wish to file a complaint against a graduate student, Licensed Professional Counselor-Intern, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Marriage and Family Therapist-Associate, Licensed Master of Social Worker, or Licensed Clinical Social Worker may write to: Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5540 or 1-512-719-3521.

Client Responsibilities

1. Taking an active part in counseling by sharing ideas and asking questions.
2. Being open to looking at problems in new ways and trying new behaviors.
3. Respecting the privacy of other people served by the agency.
4. Making a complaint if you are not satisfied with services you have received.
5. With respect to the right of the clinic, therapist may discontinue or refuse services due to the client's refusal to follow the treatment plan.
6. Any physical, emotional or sexual harassment from the client to the therapist or staff may result in termination and an immediate appropriate referral.

Financial Policy

1. I understand that if my insurance company does not pay for treatment, I will be responsible for payment in full.
2. A 24-hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay a late cancel fee of $40.00. I understand that this will be my responsibility, not that of the third-party payer.
3. Regarding accounts receivable: If at any time my balance owing is at or above $200.00, I may be asked by the therapist to reschedule to a time when my account is no longer at the limit or past due.
4. I understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.

Fees for Court-Related Services

Angels on the Horizon Therapeutic Center, LLC staff prefers to remain uninvolved in client's legal matters, including any interaction with a court system or an attorney, as it often comprises the therapeutic relationship. If your therapist is subpoenaed for depositions or court testimony, by your signature below, you agree to pay the rate of $200 per hour for all time related to court cases or litigation, this includes preparation time, travel time, actual time on location by the therapist to attend a hearing, give a deposition or testify in court, and the costs of complying with a subpoena for records or testimony regardless of which party issued the subpoena, and you agree to pay the itemized charges upon receipt of an invoice. The therapist may require a deposit for anticipated court appearances and preparation.

We will NOT perform custody evaluations. We will NOT provide recommendations regarding possession, custody, or access to minor children. We will NOT provide legal advice. These services are NOT within the scope of our practice.

Social Media

Staff at Angels on the Horizon Therapeutic Center, LLC does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the therapist's personal sites(s) will be cause for termination of the therapy.

Additional Clinic Policies and Procedures:

1. When a client is actively suicidal, the client will be escorted from Angels on the Horizon Therapeutic Center, LLC to the hospital's emergency room by a family member. If a family member is either unreachable, does not reside locally, or would be a negative impact on the client, then another responsible adult deemed by the clinical supervisor, clinical personnel, or the police will be asked to transport the client to the hospital.
2. If a client is under the influence of a substance, it is unlikely that the client would benefit from the therapeutic process at that time. Therefore, when a client is noted to be under the influence of a chemical substance or is intoxicated the therapist will terminate the session and for safety reasons may also recommend the client seek transportation by another party, such as a responsible adult or taxi service.

Consent to Treatment

I affirm that prior to becoming a client of Angels on the Horizon Therapeutic Center, LLC, I was given sufficient information to understand the nature of therapy. I consent to participate in evaluation and treatment and I understand that I may refuse services at any time. I am aware that the therapist will participate in case consultation, as required, at the clinic. My signature below affirms my informed and voluntary consent to receive therapy.

I authorize Angels on the Horizon Therapeutic Center, LLC to communicate any necessary financial information (which could include co-pays/deductibles, DOB, etc).

_____ _____

Name Date

RELEASE, INDEMNIFICATION, AND HOLD HARMLESS AGREEMENT

As a necessary and indispensable part of my being allowed to participate in Equine Assisted Therapy Activities sponsored by Angels on the Horizon Therapeutic Center LLC, I do hereby agree and represent, on my behalf and on behalf of my heirs, personal and legal representatives, successors, assigns, employees, dependents, and associates as follows:

1. I understand and acknowledge that Angels on the Horizon Therapeutic Center, LLC, its employees and agents are equine professionals and that the facilities and programs used or sponsored by Angels on the Horizon Therapeutic Center, LLC, are equine activities as defined and contemplated by Texas Civ. Prac. & Rem Code S87.001 et seq. and that any claim I may have against Angels on the Horizon Therapeutic Center, LLC, its employees, or agents is limited by Texas Law.

2. The participant hereby acknowledges that he/she has full and complete notice and understanding of all the risks inherent in equine activities which may cause, contribute to, or result in the death or personal injury of the participant or damage to the participants property (the "Risks"). These risks include, but are not limited to: (i) the propensity of equines to behave in ways that may result in injury, harm, or death to persons on or around them; (ii) the unpredictability of an equine's reaction to such things as sounds, sudden movements, and unfamiliar objects, persons, or other animals; (iii) certain hazards such as surface and subsurface conditions; (iv) collisions with other animals or objects; (v) the potential of a participant acting in a negligent manner that may contribute to injury to the participant or others, such a failing to maintain control over the equine or not acting within the participants ability; (vi) the propensity of an equine to behave in dangerous ways or to trip and/or fall; (vii) the inability of anyone whomsoever to predict or foresee an equine's reaction to excitement, weather conditions, sound, movements, objects, vehicles, persons, animals, reptiles, birds, or insects, and the effects of such reactions; (viii) the hazards of surface or subsurface conditions, including but not limited to objects or conditions on, under or protruding from the surface both latent and patent; (ix) the hazards which rocks, fences, trees, stumps, logs, bridges, ditches, bodies of water, debris, and obstacles, and any equine activity in connection therewith, may foreseeably or unforeseeably present; (x) the dangers of being struck by the equine; (xiv) any negligent act or omission by the sponsor or any owner which causes or results in the death or personal injury of the participant or damage to the participant's property; and (xi) all other risks associated with horses, [handling horses,] and related activities.

3. I also understand that some conditions and risks may be known to you, Angels on the Horizon Therapeutic Center, LLC, or your employees or agents that are unknown to me; I fully acknowledge and agree that none of you, Angels on the Horizon Therapeutic Center, LLC, or any of your employees or agents has a duty to me to advise me of any potential risks, dangers, or conditions I may encounter and I recognize that what may seem dangerous to some is commonplace to others.

4. I willingly assume any and all risks and danger inherent with or incidental to my participation in Angels on the Horizon Therapeutic Center, LLC, programs and my travel to and from Angels on the Horizon Therapeutic Center, LLC, programs or classes, and any and all activities in connection with any such activities sponsored by Angels on the Horizon Therapeutic Center, LLC.

5. I will release and indemnify you, Angels on the Horizon Therapeutic Center, LLC, and all of the agents, representatives, associates, employees, contractors, subcontractors, shareholders, successors, and assigns of Angels on the Horizon Therapeutic Center, LLC, and I will hold all of those people and entities harmless in all respects in connection with all of my activities with Angels on the Horizon Therapeutic Center, LLC, and as a result of all travel to an from any Angels on the Horizon Therapeutic Center, LLC, facility or program.

6. My agreements to indemnify and hold harmless extend to and include all damages including but not limited to any claim or negligence against Angels on the Horizon Therapeutic Center, LLC, attorney's fees, costs, and expenses that may be incurred by or claimed against Angels on the Horizon Therapeutic Center, LLC, and all agents, representatives, associates, employees, contractors, subcontractors, shareholders, successors, and assigns or Angels on the Horizon Therapeutic Center, LLC, and or yourself.

7. This Agreement shall remain valid and in full force and effect from and after the date opposite that signature of the participant until expressly revoked by the Participant in a written notice personally delivered to the sponsor.

8. If this Agreement is executed by the undersigned fro and on behalf of a minor participant named below the undersigned hereby warrants and represents that he is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor participant, his/her heirs, personal representatives, successors, and assigns; and the undersigned further agrees that this Agreement shall also be as fully binding on the undersigned as if it were entered into solely on his own behalf.

9. This Agreement shall be binding upon the heirs, personal representatives, successors, and assigns of the participant and the undersigned.

This Agreement is knowingly, willingly, and freely given, and I fully understand and agree that it is a release and waiver of certain rights I may have and shall act as a complete bar against any claims that might otherwise be brought. Any claims that may nevertheless be brought or asserted shall be my responsibility entirely.

Print Name: _____ Date:_____

Signature: _____

PARENT'S OR GUARDIANS ADDITIONAL INFORMATION
(Must be completed for participants under the age of 18)

In consideration of _____ (print minor's name) ("Minor") being permitted by Angels on the Horizon Therapeutic Center, LLC, to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold harmless Angels on the Horizon Therapeutic Center, LLC, from any and all claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Personal History Questionnaire

To provide the best possible service, we have found it very helpful to obtain information contained in this questionnaire. Answer all questions that pertain to you and your situation. If questions arise about an item in the questionnaire, please address them with your appointed therapist. Please print clearly. All information you provide will be kept confidential within the limits of confidentiality (included in this packet).

What is the reason for your visit? Include current symptoms:

Marital Status:

Marital Status: Married Divorced Widowed Separated Never Married

Name, age, & DOB of spouse:

How long married? _____

Number of previous marriages? _____

Family History:

List names, ages and gender of children in the home.

Name	Age	M/F

Please list names of other family members living outside the home or other persons living in the home.

Name	Age	M/F

Educational/Work History:

What is the last grade you completed, including GED? _____

Occupation: _____

Where do you work? _____

How long have you worked there? _____

Legal History:

List any prior trouble you have had with civilian police/authorities, including juvenile offenses (Exclude minor traffic violations, etc.)

_____

_____

List of current legal troubles (including involvement in CPS):

_____

_____

Does any family member have current legal troubles?

_____

Medical/Mental Health History:

Are you presently being treated by a physician for any medical conditions? YES NO
If so, please describe.

_____

_____

List medications you are currently taking:

_____

_____

Have you ever seen a counselor or mental health professional (psychiatrist, psychologist, social worker, or religious clergy) before? YES NO
If yes, please indicate, who, when and for what reason

_____

_____

Have you ever been hospitalized before? YES NO
If so, location and date(s)

_____

_____

Have you ever hurt yourself intentionally or attempted suicide? YES NO
If so, describe what took place

Developmental History
Did you have any problems (physical, emotional, etc.) in your early childhood? YES NO
If yes, please describe:

_____

List any childhood illnesses, serious accidents, or hospitalizations? (Include history of head injury or loss of consciousness)

_____

_____

Have you ever experienced any of the following:

Physical Abuse YES NO

Sexual Abuse YES NO

Assault YES NO

Death of a Parent YES NO

Death of a Friend YES NO

Parental separation or divorce YES NO

If so, please describe:

_____

Please describe on both parents' side of the family any history of mental illness, suicide, chemical abuse or alcohol abuse.

_____

_____

Chemical Health

Describe any current or history of alcohol or drug use.

_____

Have you ever felt you ought to cut down on your drinking or drug use? YES NO

Have people annoyed you by criticizing your drinking or drug use? YES NO

Have you ever felt bad or guilty about your drinking or drug use? YES NO

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? YES NO

Other

What would you like to see come out of services for yourself?

_____

_____

Is there any other information that would be helpful to know in helping you?

_____

_____ _____

Signature Date