DEAR NEW CLIENT,

THANK YOU FOR TAKING THIS FIRST STEP TOWARD FEELING BETTER.

FILL OUT ALL FORMS PERTAINING TO YOU, NAME, ADDRESS, BIRTHDATE ETC.

MEDICAL ASSISTANCE HAS A FEW EXTRA FORMS, WHICH ARE NOTED.

SIGN BUT DO NOT DATE ANY FORMS. WE WILL DATE THEM UPON YOUR FIRST INITIAL INTAKE APPOINTMENT.

IF YOU DON'T UNDERSTAND HOW TO COMPLETE A FORM, WE WILL FINISH IT ON YOUR ARRIVAL OF YOUR FIRST VISIT. PLEASE BE ON TIME AS THERE IS STILL SOME PAPERWORK TO FINISH.

THANK YOU AND I AM LOOKING FORWARD TO MEETING YOU,

Joan McCullough-Crissman

JOAN MCCULLOUGH-CRISSMAN

NEW HORIZONS COUNSELING

NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668 (724) 972-6409

PATIENT INFORMATION

(Please Print Neatly)

Patient's Name: _____ SSN: _____

Patient's Address: Street _____

City: _____ State _____ Zip _____

Phone Number (____) _____ Date of Birth: __/____/____ Age: _____ Sex: Male___ Female___

Email address: _____ Cell Phone #: _____

Patient's Status: Single ☐ Married ☐ Other ☐ _____

Employed (Yes/No) _____ Work and Phone # _____ School: _____ Grade: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

Please list who referred you for today's visit: _____

IF YOU ARE THE INSURANCE HOLDER OR PAYING CASH THIS SECTION IS NOT REQUIRED

Patient's relationship to subscriber: Spouse ☐ Child ☐ Other ☐ _____

Subscriber's Name: _____ Phone Number: (____) _____

Subscriber's SSN: _____-_____-_____ Subscriber's DOB: ___/___/____

Subscriber's address: Street _____ Apt. #_____

City _____ State _____ Zip _____

Please complete the following information, including all numbers and letters in policy (if applicable).

Subscriber's employer: _____ Occupation: _____

Subscriber's insurance company: _____ Deductible Amount on Plan? _____

Insurance ID#: _____ Group #: _____

Does patient have other insurance? Yes ☐ No ☐ (If yes, list company and policy/group number on back)

Primary Care Physician (include address/phone# _____

Psychiatrist (include address/phone #) _____

AUTHORIZATION FOR PAYMENT OF SERVICES

I authorize the release of any medical or other information necessary to process any insurance claim.
I authorize payment of medical benefits to New Horizons Counseling, LLC for services rendered.

Signature of Patient/Subscriber: _____ Date: _____

For Counselor Use Only

Primary Condition Dx: _____ **Code:** _____

☐ **INSURANCE:** Copay _____ Deductible _____ ☐ **CASH PAY RATE** _____

☐ **EAP:** _____ # of visits: _____ Authorization #: _____

Examining Clinician: _____ **Date:** _____

Joan McCullough- Crissman, MA, LPC

NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668

TREATMENT PLAN And AGREEMENT – *INITIAL*

Client Name _____ Diagnosis: _____

Intake Date _____ Date of Treatment Plan _____ Date of Next Review _____
(To be completed within 15 days of intake)

Estimated Length of Treatment _____ Type: Outpatient Therapy Modality: Individual ___
(Treatment Plan reviewed every 4 months or 15 sessions—whichever comes first) Location: Office Family ___
Group ___

TARGET CONCERNS/ PROBLEMS/ SYMPTOMS/ BEHAVIORS	LONG TERM GOALS (Desired changes in the condition or status of the problem)	SHORT TERM GOALS (Changes in knowledge, skill, or attitude and the resulting behavior change)	SPECIFIC INTERVENTIONS (frequency, education, coord. of care, auxillary services, activities, experiences, incl. responsible party, etc.)	TARGET DATES
			___ Less Restrictive Alternatives ___ Informed Consent Frequency: ___ WEEKLY ___ BIWEEKLY ___ WEEKLY/ ___ THREE WEEKS ___ TITRATING ___ MONTHLY _____ Refer for Medication Management to Kreinbrook Psychological Services or PCP	

Continue on Page 2

Client Strengths/ Resources:

(this document is not a guaranteed legal contract or a promise of treatment outcome)

3.15

_____ (Client: Accepted _____ Declined _____ _____

CLIENT SIGNATURE **DATE** **Initial)** **JOAN MCCULLOUGH-CRISSMAN, MA, LPC** **DATE**

NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668 (724) 972-6409

Joan McCullough-Crissman, MA, LPC

RELEASE OF INFORMATION

Patient's Name _____ Birth Date _____ Last 4 Digits - Member's SSN _____

Street Address _____ City _____ State _____ Zip Code _____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information)Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for confidentiality of alcohol and Drug Abuse Patient Records) Title 42 of the code of Federal Regulations Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.
I understand that my records may contain information regarding my mental health, substance use or dependence, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.
I also understand that my health plan may not condition treatment, payment enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in it health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying, New Horizons Counseling, LLC in writing, but if I do, it will not have any effect on any actions NHC, LLC took before it received the revocation.

I hereby authorize New Horizons Counseling, LLC to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

I hereby authorize New Horizons Counseling, LLC to exchange / release / obtain information:

☐ Verbally only ☐ in written form only ☐ both verbally and in writing

Person/organization receiving/communicating the information:

Name: _____

Address: _____

City: _____ State_____ Zip_____

Phone Number: (____) _____--_____ Extension _____

Description of Individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:

☐ All ☐ Treatment Plan(s)
☐ Clinical records ☐ Outpatient Progress Reports
☐ Attendance Only
☐ All pertinent documentation New Horizons Counseling, LLC deems appropriate for the purpose(s) checked below
☐ Other (describe): _____

The Purpose of this release is (check all that apply):
☐ To allow the clinically appropriate management and coordination of the Patients mental health and/or substance abuse treatment
☐ Other (describe): _____

The dates of records to be disclosed:
From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

THE PATIENTS OR PATIENT'S REPRESENTATIVE, MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire:
☐ On _____ (MM/D/YYYY) or one year from the date of signature below
OR
☐ Once the following event occurs: _____

(***Form must be completed before signing***)

_____ _____ _____
Signature of Patient/Legal Guardian Signature of Minor Patient Date

_____ _____
Print Name of Patient/Guardian Relationship to the Patient

_____ _____
Witness Signature Date of Witness Signature

I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

3.15

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668

ENCOUNTER FORM

Client: ______________________________ *I.D. #:* ______________________________

Diagnosis: ______________ *Date of Service:* ________________ *Type of Service: IN OFFICE/OUTPATIENT*

Billing Code: ______________ *Time of Service:* ________ - ________ *a.m./p.m.* *Units:* ________

______________________________ ________ ______________________________ ________

Signature of Client Date JOAN MCCULLOUGH-CRISSMAN, MA, LPC Date

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Client: ______________________________ *I.D. #:* ______________________________

Diagnosis: ______________ *Date of Service:* ________________ *Type of Service: IN OFFICE/OUTPATIENT*

Billing Code: ______________ *Time of Service:* ________ - ________ *a.m./p.m.* *Units:* ________

______________________________ ________ ______________________________ ________

Signature of Client Date JOAN MCCULLOUGH-CRISSMAN, MA, LPC Date

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Client: ______________________________ *I.D. #:* ______________________________

Diagnosis: ______________ *Date of Service:* ________________ *Type of Service: IN OFFICE/OUTPATIENT*

Billing Code: ______________ *Time of Service:* ________ - ________ *a.m./p.m.* *Units:* ________

______________________________ ________ ______________________________ ________

Signature of Client Date JOAN MCCULLOUGH-CRISSMAN, MA, LPC Date

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Client: ______________________________ *I.D. #:* ______________________________

Diagnosis: ______________ *Date of Service:* ________________ *Type of Service: IN OFFICE/OUTPATIENT*

Billing Code: ______________ *Time of Service:* ________ - ________ *a.m./p.m.* *Units:* ________

______________________________ ________ ______________________________ ________

Signature of Client Date JOAN MCCULLOUGH-CRISSMAN, MA, LPC Date

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NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668 (724) 972-6409

Joan McCullough-Crissman, MA, LPC

Patient Information and Agreement

Patient rights and responsibilities:

Every patient of New Horizons Counseling, LLC is entitled to:
- ☐ Participate in treatment decisions during his or her care.
- ☐ Be treated at all times with dignity and respect by counselors and staff.
- ☐ Voice a complaint or appeal a decision about care provided.

Every patient being treated by New Horizons Counseling, LLC has a responsibility to:
- ☐ Provide information the counselor needs to give appropriate care.
- ☐ Follow the counselor's recommended plans and instructions for care.
- ☐ Participate in the treatment process through a focus on problems and the development of mutually agreed upon treatment plans and goals.
- ☐ Inform the staff of any changes in your health insurance coverage.
- ☐ Keep scheduled appointment and comply with your insurance provider's cancellation policy.

Privacy and Confidentiality

Your patient records are protected from disclosure under both state and federal laws relating to mental health services. Conversations and test results are held in strict confidence unless otherwise provided for by state or federal regulations such as: You are a danger to yourself or to others, or a child is endangered. If your counselor needs to consult with someone regarding your treatment, you will be asked to sign a release form that will clearly identify the information to be exchanged, the parties involved in the exchange, and the reason for the communication.

Fees and payments

Initial Psychiatric Evaluation:	$164.00	Family Therapy/Patient	$133.00
Psychotherapy (55 – 60 Min.):	$159.00	Crisis – Initial 60 min.	$165.00
Psychotherapy (45 Min):	$105.00	Crisis – Add'l 30 min.	$ 79.00
Psychotherapy (30 Min.):	$ 79.00		

Appointment Scheduling, cancellation and no-show policies

All appointments are scheduled by your assigned counselor. Every attempt will be made to schedule times that are convenient for you. If you are unable to keep your scheduled appointment, New Horizons Counseling, LLC requires a 24-hour advance cancellation notice. **Without this notice, you will be charged a $35 cancellation fee.** Interest can be attached to any extended unpaid balance.

Clinical emergency and after-hours procedures

Normal office hours are Monday through Saturday by appointment from 9 am to 9 pm. During this time, your assigned counselor is available to return your call. If you are experiencing a clinical emergency after regular business hours, please call 911 or go to your nearest hospital emergency waiting room.

We are happy to file any insurance forms as a courtesy to you to ensure that you receive the full benefits of your policy. Your insurance policy is an agreement negotiated between you or your employer and the insurance company. We are only an outside third party to this agreement, and we cannot make a guarantee of any estimated coverage. We remind you that regardless of your insurance coverage, our services are provided to you and ultimately you are financially responsible for payment. Please clarify with us and keep current the status of your insurance coverage prior to and throughout treatment. If you are uncertain about your coverage, please consult your insurance provider for details.

For all other questions, including billing procedures and statement balances, please contact us at 724-972-6409.

Termination of treatment

You may terminate treatment for any reason. Upon your request, New Horizons Counseling, LLC will be happy to provide you with a referral to another qualified provider. If you sign a release of information at that time, New Horizons Counseling, LLC will gladly forward a copy of your records to your new provider. If you cancel more than three appointments in any two-month period, or do not appear for two or more appointments within three months without giving 24-hour notice, your care may be transferred to another provider, at New Horizons' discretion.

Patient Agreement I agree that I have read and understand the policies stated above. I acknowledge that I may request a copy of this Patient Information and Agreement form. I understand that a copy of this Agreement will be kept on file.

Patient Signature_____ Date_____

NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668 (724) 972-6409

Joan McCullough-Crissman, MA, LPC

CONSENT TO TREATMENT

Client Name _____ Date of Birth:____/____/____ Diagnosis: _____

I have received a copy of my *Patient Information and Agreement* as a client of New Horizons Counseling, LLC. This includes information about the nature of counseling, as well as guidelines for an effective counseling process.

I also have received a copy of New Horizon Counseling, LLC's *Notice of Privacy Practices*, which explains the ways in which confidential medical information may be used, disclosed, or accessed according to federal law and as contained in the *Health Information Portability and Accountability Act* (HIPAA),effective April 14, 2003. I understand that it is my right to read these documents before signing this form, and that I am entitled to a copy of this and any other consent form that I sign.

I am aware that communication with my counselor is noted and kept in a confidential file. I understand that, unless I authorize and sign a release of information form, it is the provider's policy to safeguard any information it gathers about me, as well as the medical records it compiles, from anyone who is not directly involved in my treatment. I further understand that, in cases of couple or family counseling, all participants over the age of 18 must authorize this release.

I understand that HIPAA mandates some exceptions to absolute confidentiality. These include:

1. The counselor's right to use or disclose any medical information that may be required for purposes of carrying out treatment and related healthcare operations, and for obtaining payment for services. Billing is done online and Clients Files are sent online with encryption.

2. The requirement that the counselor shares with the proper authorities: reports or evidence of child abuse; reports or actions of suicidal or homicidal intent; and situations of life-threatening medical emergency. In such instances, my consent is not required.

I understand that I may request additional restrictions, beyond those stipulated in HIPAA, on the use and disclosure of my medical information, and that, while not required to agree to such requests, the counselor will cooperate as far as possible. Where there is agreement, however, the restrictions will be binding on the counselor.

I understand that, although my file is the property of the counselor's, I have a right to review and discuss the information in it, or to obtain a copy or summary of it at a reasonable charge.
I am aware that my counseling relationship with the New Horizons Counseling, LLC counselor will not deprive me of any civil rights, nor will I be discriminated against by the New Horizons Counseling, LLC counselor.

I have been informed of my counseling fee and of the payment schedule.

I have been informed of the nature, purpose, benefits and risks of treatment/services involving outpatient counseling provided in office by Joan McCullough-Crissman at New Horizons Counseling, LLC, 4578 William Penn Highway, Murrysville, PA 15668.

I have been informed of the benefits and risks of treatment, alternative treatments, and also the risks and benefits of not receiving any treatment or services.

By signing below, I consent to treatment and acknowledge that New Horizons Counseling, LLC and its physicians, employees, or agents may use or disclose my medical information as deemed appropriate (and according to state and federal law) to carry out treatment and related health-care operations, and to obtain payment for services.

_____ _____

Signature of Client or Legal Representative Date/ Time-End of Session

If you are a legal representative, please check the basis for your authority:

- Custodial Parent
- Guardianship Order (attach copy)
- Power of Attorney (attach copy)

_____ _____

Provider: Joan McCullough-Crissman, MA, LPC Date

THE FOLLOWING FORMS ARE TO BE INCLUDED WITH MEDICAL ASSISTANCE CLIENTS OR VALUE BEHAVIORAL HEALTH CLIENTS FOR WESTMORELAND COUNTY.

IF YOU ARE AN ALLEGHENY COUNTY CLIENT – COMMUNITY CARE - YOU ARE NOT ELIGIBLE TO BE SEEN IN WESTMORELAND COUNTY WITH MY PRACTICE, UNLESS THERE ARE SPECIAL CIRCUMSTANCES.

NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668 (724) 972-6409

Joan McCullough-Crissman, MA, LPC

RELEASE OF INFORMATION

Patient's Name _____ Birth Date _____ Member ID#: _____

Street Address _____ City _____ State _____ Zip Code _____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information)Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for confidentiality of alcohol and Drug Abuse Patient Records) Title 42 of the code of Federal Regulations Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.
I understand that my records may contain information regarding my mental health, substance use or dependence, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.
I also understand that my health plan may not condition treatment, payment enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in it health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying, New Horizons Counseling, LLC in writing, but if I do, it will not have any effect on any actions NHC, LLC took before it received the revocation.

I hereby authorize New Horizons Counseling, LLC to (check all that apply):
X Exchange with ☐ Release to ☐ Obtain from the parties I have indicated below

I hereby authorize New Horizons Counseling, LLC to exchange / release / obtain information:
☐ Verbally only ☐ in written form only X both verbally and in writing

Person/organization receiving/communicating the information:

Name: VALUE BEHAVIORAL HEALTH OF PENNSYLVANIA
(Billing Services for PA Health Insurance Programs)
and Gateway, UPMC for You, PA Chip Programs, United Behavioral Health Insurance Company - Carrier.

Address: 520 PLEASANT VALLEY ROAD

City: TRAFFORD State: PA Zip: 15085

Phone Number: (724) 744--3355

Description of Individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:

☐ All ☐ Treatment Plan(s)
☐ Clinical records ☐ Outpatient Progress Reports
☐ Attendance Only
☐ All pertinent documentation New Horizons Counseling, LLC deems appropriate for the purpose(s) checked below
X Other (describe): Treatment Records and Initial Evaluation for Coordination of Care and Billing

The Purpose of this release is (check all that apply):
☐ To allow the clinically appropriate management and coordination of the Patients mental health and/or substance abuse treatment
X Other (describe): BILLING FOR SERVICES

The dates of records to be disclosed:
From _____ (MM/DD/YYYY) To PRESENT DAY (MM/DD/YYYY)

THE PATIENTS OR PATIENT'S REPRESENTATIVE, MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire:

X Once the following event occurs : Termination after last session has been billed and payment satisfied by VBH.
(***Form must be completed before signing***)

_____ _____
Signature of Patient/Legal Guardian Signature of Minor Patient Date

_____ _____
Print Name of Patient/Guardian Relationship to the Patient

_____ _____
Witness Signature Date of Witness Signature

I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

_____ Yes _____No A copy of this form has been requested and received: _____Client Initial

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668 (724) 972-6409

I _____, have been informed that I have the right to choose a mental health provider. I have had the opportunity to discuss my treatment/service needs with _____ _____, who informed me of the choices available and if necessary, has offered to (name of staff) assist me to schedule an appointment. I have been advised that if I would like to discuss further options for treatment that I can call:

Value Behavioral Health

Armstrong County	1-877-688-5969
Beaver County	1-877-688-5970
Butler County	1-877-688-5971
Fayette County	1-877-688-5972
Greene County	1-877-688-5973
Indiana County	1-877-688-5974
Lawrence County	1-877-688-5975
Washington County	1-877-688-5976
Westmoreland County	1-877-688-5977
TTY (Hearing Impaired)	1-877-688-8502

Member's Signature:_____ Date:_____

Staff Signature:_____ Date:_____

VALUE BEHAVIORAL HEALTH
of PENNSYLVANIA
A VALUEOPTIONS® COMPANY

ACCESS STANDARDS TOOL

Member Name:	
Date of call for initial appointment:	
Time of Call:	
Type of appointment as identified by the member:	☐ Emergent ☐ Urgent ☐ Routine
Date of first appointment offered:	
Date of actual first appointment:	
Type of service:	☐ MD or ☐ Therapist ☐ Nurse
Reason for delay:	