Toni J. Horvath

Marriage, Family & Child Therapist
www.tonihorvath.com

5330 Primrose Drive, Suite 240
Fair Oaks, CA 95628

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Referred by _____

Please indicate if messages can be left or mail sent:

Home Phone: ☐ yes ☐ no Work Phone: ☐ yes ☐ no Cell Phone: ☐ yes ☐ no Home Address: ☐ yes ☐ no

In case of emergency, please contact _____ Phone: _____ Relationship: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Age: _____ Marital Status (circle): S M W Se D # Years Married: _____ Spouse Name: _____

Children (names & ages): _____

Place of Employment: _____ Occupation: _____

Briefly describe why you are seeking therapy at this time:

_____

_____

_____

Primary Care Physician: _____ Phone: _____

Do we have your permission to coordinate care with your Primary Care Physician? ☐ yes ☐ no

Date of last physical examination? _____

Treating Psychiatrist: _____ Phone: _____

Current Medications: Dosage Prescribing Physician

_____

_____

_____

_____

Previous Therapist: _____ Dates of Service: _____

Issues addressed in therapy: _____

_____

_____

_____

Do you currently have any medical conditions that you are being treated for? ☐ Yes ☐ No

Please explain. _____

_____

_____

If you have ever been hospitalized please list when and for what reason. (Please include pregnancy and abortion)

_____

_____

_____

Have you ever experienced any trauma in your life? ☐ Yes ☐ No If so, please briefly explain. _____

_____

_____

_____

List 5 things about yourself that you like: _____

_____

_____

_____

_____

List 5 things about yourself that you would like to change: _____

_____

_____

_____

_____

What are your major strengths? _____

_____

Have any anniversaries of important or stressful events in your life occurred recently or are any due to occur soon?

_____

_____

List any major problems or stressful events that other family members or close friends are currently dealing with:

_____

_____

_____

What solutions or efforts have you tried to solve the problems that bring you here? _____

_____

Do you have any religious affiliation? _____ If so, what denomination? _____

Are you ☐ practicing or ☐ non practicing in your faith?

Do you want to have your faith integrated into therapeutic treatment? ☐ Yes ☐ No

Family History

Relationship	Living	Deceased	Age	If living, location
Mother:				
Father:				
Brothers:				
Sisters:				

Is there any family history of mental illness? ☐ Yes ☐ No

Are there issues with your family of origin that you believe are influencing the quality of your life today? If so, please describe:

_____

_____

Do you drink alcohol? ☐ Yes ☐ No

If so, how much beer, wine or hard liquor do you consume each week on the average? _____

Have you ever felt the need to cut down on your drinking? ☐ Yes ☐ No

Have you ever felt annoyed by criticism of your drinking? ☐ Yes ☐ No

Have you ever felt guilty about your drinking? ☐ Yes ☐ No

Have you ever had a Driving Under the Influence arrest? ☐ Yes ☐ No Date: _____

Do you smoke cigarettes? ☐ Yes ☐ No How many packs per day? _____

Do you have any compulsive behaviors that you would like to address in therapy? _____

_____

_____

_____

Office Policies & Confidentiality

My fee for service is $140.00 for a 50 minute session for individual therapy. Except for brief messages or reports, I charge for report writing, phone therapy, email responses or other professional services at a rate of $120.00 per hour in 15 minute intervals. Payment is required at the time of each session. If you are having difficulty paying your bill, then we can talk about a payment schedule.

Many health insurance policies cover the services of a professional family therapist. Nevertheless, the reimbursement varies considerably from company to company and from policy to policy. Also, most policies have annual deductibles, copayments, or other limits on benefits. Read your policy carefully and be aware of what is or is not covered. You may wish to call your employer's personnel department to ask about your benefits. It is your responsibility to initiate the authorization from your insurance company.

You are responsible for payment of services should there be any non-coverage from your insurance company. **Initials**_____

I ask for a 24-hour cancellation notification prior to appointment unless there is an emergency. Failure to do this will result in billing for the entire missed appointment fee as I do not bill insurance companies on missed appointments. **Initials**_____

Psychological services are best provided in an atmosphere of trust. You expect me to be honest with you about your problems and progress. I expect you to be honest with me about your expectations for services, your compliance with medication, and any other factors that may be barriers to treatment.

Because trust is so important, all services are confidential. Everything you say to me remains within the office walls. Nevertheless, I am required by law to make exceptions in narrow circumstances such as when there is a suspicion of child or elder abuse, immediate danger to another person or self, or other rare circumstances.

I will take all necessary precautions to protect your privacy. My records are considered confidential and are not available for anyone to view without proper releases of information signed. No information will be disclosed without your written consent. The only exception to this is if I receive a valid and accurately prepared court ordered supoena. If you are using insurance or an Employee Assistance Plan to help with the payment of therapy services, I am required to disclose information regarding your diagnosis, dates of service, and progress in treatment.

I understand the above statement of policy.

_____

Printed Name

_____

Signature Date

I am in receipt of the "Notice of Privacy Practices".

_____

Signature Date

Release of Information For Billing Purposes

If you request that I complete insurance forms, you authorize me to make disclosure of your diagnostic information and dates of therapy sessions. Upon revocation of this authorization, further release of information shall cease immediately. This release of information for the purposes of a claim for benefit payment(s) expires upon termination of coverage under the insurance policy or benefit plan or the final determination of the claim, if later.

Executed this _____ day of _____, 20 _____

_____ _____

(PATIENT) (WITNESS)

_____

(Parent, Guardian if REQUIRED)

Insurance Information

Please bring in your insurance card or a copy of the front and back with you to your first session.

Insurance Company _____ Insurance Plan Name _____

Primary Insured's Name _____ Primary Insured's Birth date _____

Patient's Relationship to Insured: _____

Primary Insured's Employer's Name _____

Is there another Health Benefit Plan? ☐ Yes ☐ No If so, what _____

For Office Use Only

Authorization #: _____ # Visits Authorized_____Copay _____

Dates of Service: _____ to _____

Toni J. Horvath, L.M.F.T.

5330 Primrose Drive, Suite 240 • Fair Oaks, CA 95628
(916) 368-6449 Fax: (916) 961-1107 License# MFC31439
This notice is required by federal law

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

I. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your Protected Health Information (PHI) is kept private and safe. I may *use* or *disclose your protected health information* (PHI), for certain *treatment, payment and health care operations* purposes without your *authorization*. In certain circumstance, I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

• *"PHI"* refers to information in your health record and constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care.

• *"Treatment and Payment Operations"*
- *Treatment* is when I provide or another healthcare provider diagnosis or treats you. An example of treatment would be when I consult another health care provider, such as your family physical or psychiatrist, psychologist, marriage family therapist, social worker, regarding your treatment.

- *Payment* is when I obtain reimbursement for you healthcare. Examples of payment are when I disclose your PHI to your health insurer for payment or to determine eligibility or coverage.

• *"Health Care Operations"* is when I disclose your PHI to your health care service plan (your health care insurer), or to your other health care providers contracting with your plan, for administrating the plan, such as case management and care coordination.

• *"Use"* applies only to activities within my office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.

• *"Disclosure"* applies to activities outside my office such as releasing, transferring or providing access to information about you to other parties. • "Authorization" means written permission for specific uses or disclosures.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

I may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. In those instances when I am asked for such, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session. Which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke or modify all such authorization (of psychotherapy or psychotherapy notes) at any time; however, the revocation or modification is not effective until I receive it.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances: • Child Abuse: Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect, has been the victim of child abuse or neglect, I must immediately report such to a police or sheriff 's department, county probation department, or county welfare department. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, I may report such to the above agencies.

• **Adult and Domestic Abuse:** Whenever I, in my professional capacity, have knowledge of or observe an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or local law enforcement agency. I do not have to report such an incident if: 1) I have been told by an elder or dependent adult that he or she has not experience behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect; 2) I am not aware of any independent evidence that corroborates that the abuse has occurred; 3) The elder or dependent adult has been diagnosed with a mental illness or dementia; and 4) In the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

• **Serious Threat to Health or Safety to Other Person:** If you communicate to me a serious threat of physical harm or violence against and identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to others, I may release relevant information as necessary to prevent the threatened danger.

• **Serious Threat to Health or Safety to Yourself (Suicide):** If you communicate to me a serious threat of physical harm or if I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself, I may release relevant information as necessary to prevent the threatened danger. I may provide PHI to law enforcement or persons able to prevent or mitigate a serious threat to the health or safety of yourself.

• **For Treatment.** I may disclose your PHI to your physicians, psychiatrists, and other providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

• **To Obtain Payment for Treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

• **Health Oversight:** If a compliant is filed against me with the California Board of Behavioral Science, the Board has the authority to subpoena confidential mental health information from me relevant to that compliant.

• **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have notified me that you are bringing a motion in the court to block or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.

• **Worker's Compensation:** I may provide PHI in order to comply with Workers' Comp. laws.

• **Appointment Reminders And Health Related Benefits Or Services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.

• **Other. Examples:** Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered.

IV. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

• **Disclosures to Family, Friends, or Others.** Though it is my policy to not disclose any information about your treatment nor acknowledge that you are my patient to anyone without your consent or knowledge, except where stated above, I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment of your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

• **Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in sections I, II, III and above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to

stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

V. PATIENT'S RIGHTS AND LICENSED THERAPIST'S DUTIES:

• *Right to Request Restrictions:* You have the right to request how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

• *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You have the right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (via email instead of by regular mail).

• *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of this amendment process.

• *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described above sections). On your request, I will discuss with you the details of the accounting process.

• *Right to Amend:* You have the right to request an amendment of PHI for as long as PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

• *Right to a Paper Copy or Email:* You have the right to get this notice by email or paper copy.

Licensed Therapist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices describes in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my polices and procedures, I will provide a copy of that change to you.

VI. COMPLAINTS

If, in your opinion, I may have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the state department of consumer affairs, Board of Behavioral sciences. You may also send a written complaint to the secretary of the U.S. Department of Health and Human Services. . I will take no retaliatory action against you if you file a complaint about my privacy practices.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Nor Cal Medical Billing, Attn: Privacy Officer, P.O. Box 1561, Placerville, CA 95667 (530)622-1017. You will not be retaliated against or penalized for making a complaint.

VII. EFFECTIVE DATE OF THIS NOTICE:

This notice went into effect on April 6, 2007. Your signature below acknowledges that you received a copy of this notice. The signed copy will be retained in my file.

_____

Client Signature

_____

Date