Elisa Horton, LMFT, LMHC, NCC, Inc - www.elisahorton.com - 772-426-9955; fax 772-781-8388

Instructions – please read!!!!

For "the client" - please make sure you go to my website, click the New Client tab, and click on the link that takes you to the portal where you enter your username and password given to you during our initial discussion when we set the appointment. Once in the portal - please click on "update your contact or insurance information" and complete the requested information for your chart.

For everyone attending therapy:

1) Every person who will be regularly involved in therapy due to the presenting issues is asked to fill out the **Clinical Information Form** (please make copies and distribute to all regular attendees). Please make this form as complete as possible so we can utilize our first session effectively without having to pause to complete incomplete information. If the client is a child under the age of 13 (or is somehow otherwise in need of assistance in understanding how to complete these questions) a parent/guardian should be involved in assuring this document is completed appropriately.
2) The **Acknowledgement of the Notice of Privacy Practices (NPP)** will need to be signed by everyone who attends therapy after they have read and understood the NPP document that is on my website at http://www.elisahorton.com/app/download/7236876890/HIPAA+NPP+v09.2013.1+update.pdf .
3) The **Agreement to the Informed Consent for Treatment (IC)** will need to be signed by everyone who attends therapy after they have read, understood and legally agreed to the IC document that is on my website at http://www.elisahorton.com/app/download/7236876871/Elisa+Horton+informed+consent+v09.2013.1.pdf .
4) The **No Secrets Policy** section only needs to be completed if Elisa is treating a couple or a family as the patient (e.g. if sessions are mostly couples or therapy sessions/if that is the point of treatment). The full document should be read and understood before signing can be found here: http://www.elisahorton.com/app/download/7054139004/No+secrets+11.1.12.pdf
5) The **Release of Information/Exchange of Information form** needs to be filled out if there is someone I should be speaking with about your treatment (e.g. your doctor or psychiatrist). If I see you in the context of family or couples therapy – I will need the permission (a release filled out) of everyone ever seen in order to release information about you to anyone as per FL Statute 491.0147 (2).

For those using Insurance or Employee Assistance Programs

1) The insurance section only needs to be completed if there is medical insurance being used and needs to be completed by the covered entity who presents with symptoms that would qualify for medical treatment.
2) The EAP form only needs to be completed if the covered person's Employee Assistance Program is being utilized and needs to be completed by the covered entity/the employee who has the benefit and who has attained authorization for treatment.

For Divorced, Separated, or Otherwise Shared Custody Parents of Non-Emancipated Minors who will be seen in therapy:

1) Please have the non-attending parent/legal guardian sign the **Non-Intact Family Agreement** which acknowledges that they understand that their child is seeing me and that they have a right to speak with me about their child and their child's treatment. The child cannot be seen without this form being fully completed and signed. There is a section to check off if the other parent has been TPRed. I cannot see/continue to see the child if this form has not been completed.

For the Client/Responsible Party:

1) Please complete the **Appointment Reminder** form.
2) Please complete the **Credit Card on File** form (my practice accepts cash or check only for regular visits - credit cards are a last resort for unpaid fees).

Thank you for your cooperation!

Clinical Intake Form

Client Information: **(*if you have already completed the contact info on the portal - skip filling out the contact info here.)**

Last name: _____ First name: _____
DOB: _____ Age: _____ Gender: _____ Race: _____
Marital Status: _____ Employer/School: _____

*Full Address (Apt#, City, Zip): _____
*Home Phone: (_____) _____ Can a message be left? *At Home:* ☐ yes ☐ no
*Cell Phone: (_____) _____ Can a message be left? *On Cell:* ☐ yes ☐ no
*Work Phone: (_____) _____ Can a message be left? *At Work:* ☐ yes ☐ no
*Number preferred to be contacted at: ☐ Home ☐ Work ☐ Cell
*E-Mail Address: _____ Can a message be left? *E-mail:* ☐ yes ☐ no

*Parent/Guardian Name (if relevant): _____
*Address (☐ same as client): _____
*Phone Number (where a message can be left): (_____)_____

*Emergency Contact (☐ same as parent/guardian): _____Relation: _____
*Address: _____
*Phone Number (where a message can be left): (_____)_____

Presenting Problem:
Please briefly indicate the concern(s) that bring you into counseling at this time:_____
_____
_____

Is this problem impacting your: ☐ Work ☐ School ☐ Social life ☐ Relationships ☐ Ability to function

How long have you been dealing with this concern? _____

What has helped your progress? _____

What has impaired your progress? _____

What specific goals/objectives would you like to work on in therapy? Please make goals: specific, measurable, objective, and/or behaviorally oriented – also, please make them about changes you would like to make not changes you'd like others to make. Another way of thinking about this is – how will you know when therapy is complete or what would you like to have happen as a result of therapy?:

1. _____
   _____
2. _____
   _____
3. _____
   _____

How did you learn about my practice?
_____

Personal Strengths Characteristics: _____

Coping Tools/Self Care: What do you do to take care of yourself socially, physically, intellectually/mentally, creatively, emotionally, & spiritually? _____

_____

_____

Support System: Who do you turn to for support?: _____

Please list those that live in your household:

Name	**Relation**	**Age**	**Live w/FT? yes=✓**	**Quality of Relationship – i.e. Close, Good, Fair, Poor, Enmeshed, Strained/Conflictual, Non-existent, etc**

Current Psychiatric Care or Counseling:

Are you currently seeing a psychiatrist □Yes □ No – if yes, please list who: _____
Do they know you are seeing me? □Yes □ No – If No, can they be informed? □Yes □ No (if yes, please sign a release)

Are you currently seeing a another therapist? □Yes □ No – if yes, please list who and what service they are providing for you (i.e. marital counseling):_____
Do they know you are seeing me? □Yes □ No – If No, can they be informed? □Yes □ No (if yes, please sign a release)

Medical: □ I do not have a regular doctor – but my last medical exam was (month/year) _____

Primary Care Physician: _____

How long with this physician? _____ Date of Last Visit: _____ Phone #: _____

Are they aware you are seeking counseling? ☒yes ☒no Can they be contacted? □Yes □ No (if yes, please sign a release)

Describe Current Medical Problems: □ N/A

Medical Problem	Medication, Supplements, Vitamins, & Herbs	Dose & Frequency	Prescribed By Whom?	Duration of treatment?

Please indicate any current medical issues or symptoms that you have not told your doctor about: □ N/A _____

Please describe relevant past medical history (i.e. hysterectomy, cancer, strokes, heart attacks): □ N/A _____

Please indicate any significant family medical history: □ N/A, □ cancer, □ cardiac disease, □ thyroid or endocrine problems, □ HBP, □ stroke, □ other: _____

Please list any pre-natal, post-natal or developmental challenges you've (the client) has had: _____

** Please indicate any and all medications and other substances to which you are allergic: □ N/A _____

Family History/Information:

Are your parents: ____ Married/Partnered ____ Separated ____ Divorced (year____) ___Never Married
Your current status: ____ Married/Partnered ___ Re-married ____ Separated ____ Divorced (year_____) ____Single

Other than the people you live with please indicate the following (do NOT include people you live with):

	First Name	Age	De-ceased? yes=✓	Local? yes=✓	Quality of Relationship – i.e. Close, Good, Fair, Poor, Enmeshed, Strained/Conflictual, Non-existent, etc
Mother: □ unknown					
Father: □ unknown					
Step-Mother(s):					
Step-Father(s):					
Siblings:					
Children:					

Custody Arrangements: ☐ N/A

If you are a parent (or if you are a minor and you/your parents are divorced), what is the time share/custody arrangement (i.e. do you have them on weekends & holidays, etc):_____

Psychiatric/Psychological/Counseling Treatment History: ☐ Check here if this is your first and only experience.

Have you *ever* been hospitalized or in-patient treatment for a mental health or substance abuse issue? ☐ Yes ☐ No

Year	Length of Stay	Treatment Facility	Reason(s)

Have you *ever* received any other mental health services (i.e. psychiatric care or counseling) of any kind? ☐ No ☐ Yes

Year	Length of Tx	Name of Provider (& type)	Diagnosis or Reason(s) for Treatment	Medications Given &/or Therapy/Counseling
				Meds? Y/N Therapy? Y/N
				Meds? Y/N Therapy? Y/N
				Meds? Y/N Therapy? Y/N
				Meds? Y/N Therapy? Y/N
				Meds? Y/N Therapy? Y/N

Can above listed practitioners or facilities be contacted about the care you received? ☐ Yes (release needed) ☐ No

Family Psychiatric History: Please indicate any family history of psychological symptoms or disturbances (i.e. depression, anxiety, psychosis, addiction, etc): □ N/A _____

_____

Risks:

Are you currently feeling like you want to hurt or kill yourself? ☐ yes ☐ no Do you have a plan? ☐ yes ☐ no

Are you currently feeling like you want to hurt or kill someone else? ☐ yes ☐ no Do you have a plan? ☐ yes ☐ no

Do you purposefully, physically hurt yourself? ☐ yes ☐ no – If yes – how:_____

Are you currently being abused? ☐ yes ☐ no If yes, by who and how?_____

Are you currently involved in or being exposed to a relationship that contains domestic violence? ☐ yes ☐ no

*Do you have a history of ANY of the previous risks listed above? ☐ yes ☐ no If yes, please explain: _____

_____

Substance Use History:

Substance	Current Use?	Past Use?	Age of 1st use?	Legal, Vocational or Relational consequences?	Quantity of servings per week on average in last 3 months:	Do you feel it's a current problem for you?	Have you had treatment for it?
Alcohol	Y / N	Y / N		Y / N		Y / N	Y / N
Nicotine	Y / N	Y / N		Y / N		Y / N	Y / N
Pot	Y / N	Y / N		Y / N		Y / N	Y / N
Coke or Crack	Y / N	Y / N		Y / N		Y / N	Y / N
Opiates	Y / N	Y / N		Y / N		Y / N	Y / N
Benzodiazepines	Y / N	Y / N		Y / N		Y / N	Y / N
Uppers/Speed	Y / N	Y / N		Y / N		Y / N	Y / N
Crystal Meth	Y / N	Y / N		Y / N		Y / N	Y / N
Prescription misuse/abuse	Y / N	Y / N		Y / N		Y / N	Y / N
Other:	Y / N	Y / N		Y / N		Y / N	Y / N

In the last three months, have you felt you should cut down or stop drinking or *using drugs?* ❍*Yes* ❍ *No*
In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs?* ❍*Yes* ❍ *No*
In the last three months, have you felt guilty or bad about how much you drink *or use drugs*? ❍*Yes* ❍ *No*
In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs*? ❍*Yes*❍ *No*

Is someone else's substance use affecting you? If yes, explain: _____

Traumatic Events (where you have experience fear of harm or death of you or someone else): □ N/A

Event/What	How long ago?	Is it affecting you now? How?
		☐ flashbacks ☐ nightmares ☐ intrusive thoughts ☐ fear/ numbness ☐ triggered by noises or other reminders ☐ other:
		☐ flashbacks ☐ nightmares ☐ intrusive thoughts ☐ fear/ numbness ☐ triggered by noises or other reminders ☐ other:
		☐ flashbacks ☐ nightmares ☐ intrusive thoughts ☐ fear/ numbness ☐ triggered by noises or other reminders ☐ other:

Loss History: (i.e. death of a loved one or pet, divorce, job, etc) □ N/A

Who/What	How long ago?	Is it affecting you now? How?

Religious/Spiritual Orientation: □ N/A. Please note your orientation: _____

Sexual Orientation: _____

Educational Background: □ Currently a PT student □ Currently a FT student
Highest level of education completed: _____ Where:_____

Military History: □ N/A. Have you, your spouse, or any of your family ever been in the military? Please explain:

_____

How has this impacted you &/or your family? _____

_____

Occupation/Employment/School: □ Employed FT □ Employed PT □ Unemployed □ Disabled □ Retired □ Student
Occupation _____ Name of Employer/School: _____

Duration of employment/disability/unemployment/school: _____ years Performance: □ Good □ AVG □ Poor

How do you feel about your job/school?_____

Financial:
Are you currently experiencing financial difficulties? **Y/N** If yes, explain: _____

_____

Legal Issues:
Are you currently involved in any legal issues? **Y/N** If yes, explain: _____
Do you expect to become involved in any legal issues? **Y/N** If yes, explain: _____
Do you have a history of legal issues? **Y/N** If yes, explain: _____

Current Symptoms in last week to 2 weeks	n/a	mild	moderate	severe
Depressed mood (sad, irritable, blue, down, etc) that last most of the day	□	□	□	□
Loss of interest or pleasure in normally enjoyable things	□	□	□	□
Change in appetite or weight (i.e. significantly changing weight without trying)	□	□	□	□
Failing to keep up with important daily activities (i.e. bills, showers, etc)	□	□	□	□
Sleep disturbance (too much or too little)	□	□	□	□
Decrease/Increase in physical activity (that is uncharacteristic of you normally)	□	□	□	□
Fatigue or loss of energy (i.e. I can't bring myself to do anything)	□	□	□	□
Feeling worthless or excessively guilty	□	□	□	□
Impaired concentration or distractibility	□	□	□	□
Withdrawn	□	□	□	□
Suicidal thinking	□	□	□	□
Thoughts of death	□	□	□	□
Irritable or elevated mood (i.e. frenzied/manic, wound up, aggravated for days)	□	□	□	□
Significant mood or energy swings (each swing last 4 + days – people notice)	□	□	□	□
Inflated self esteem (i.e. I feel I can do in 1 hr what takes someone else 4 hrs to do)	□	□	□	□
Pressure of speech (i.e. I just keep talking and talking)	□	□	□	□
Racing thoughts (i.e. my thoughts spin, race and/or keep me up at night)	□	□	□	□
Excessive spending (i.e. I only have $20 extra a month - I spend $200 instead)	□	□	□	□
Acting out home (i.e. sneaking out, yelling, being disrespectful)	□	□	□	□
Current Symptoms in last week to 2 weeks	n/a	mild	moderate	severe
Acting out school &/or work (i.e. getting in fights, being argumentative, rebellious, etc)	□	□	□	□
Acting out sexually (risky behaviors – i.e. multiple partners, unprotected sex)	□	□	□	□
Acting out stealing (taking things that don't belong to me)	□	□	□	□
Acting out self mutilation (i.e. cutting, burning, scratching myself)	□	□	□	□

Using drugs or alcohol excessively (i.e. taking meds/drugs not prescribed or more than prescribed; drinking until drunk; mixing drugs & alcohol; numbing out)	□	□	□	□
Hyperactivity (i.e. I can't sit still)	□	□	□	□
Impulsivity (i.e. I don't think before I act)	□	□	□	□
Excessive fear or worry (i.e. I worry about a lot of different things)	□	□	□	□
Elevated heart rate when anxious or upset (i.e. my heart races)	□	□	□	□
Sweating when anxious or upset (i.e. when it's not hot sweating uncontrollably)	□	□	□	□
Shaking when anxious or upset (i.e. my body shakes uncontrollably)	□	□	□	□
Shortness of breath when anxious or upset (i.e. feel like can't catch my breath)	□	□	□	□
Choking when anxious or upset	□	□	□	□
Chest pain when anxious or upset	□	□	□	□
Nausea when anxious or upset	□	□	□	□
Lightheaded when anxious or upset	□	□	□	□
Feeling of unreality when anxious or upset	□	□	□	□
Numbness or tingling when anxious or upset	□	□	□	□
Fear of losing control because I'm feeling anxious or upset	□	□	□	□
Chills or hot flashes when anxious or upset	□	□	□	□
Feeling of impending doom (i.e. feeling something terrible is going to happen)	□	□	□	□
Avoidance of social situations due to panic/intense anxiety	□	□	□	□
Recurring unwanted thoughts that cause distress	□	□	□	□
Repetitive behaviors (i.e. counting, checking locks, skin picking, hair pulling, etc)	□	□	□	□
Reliving life threatening events	□	□	□	□
Auditory hallucinations (hearing things not really there)	□	□	□	□
Visual hallucinations (seeing things not really there)	□	□	□	□
Cognitive impairment (forgetting important things or events, the date, people, short or long term memory loss, loosing words often, etc)	□	□	□	□

Other symptoms you are experiencing that are not listed: _____

_____

These symptoms are: □ distressing □ not distressing
These symptoms are affecting my: □ work □ school □ relationships □ability to function normally in daily life

Thank you!

Acknowledgement of the Receipt of the Health Insurance Portability and Accountability Act ("HIPAA) Notice of Privacy Practices (NPP) - Effective 9/23/13

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Elisa Horton, LMFT, LMHC, NCC, Inc's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Elisa Horton at (772) 426-9955.

Adult Client Name (Printed)	Date of Birth	Signature	Date
Adult Client Name (Printed)	Date of Birth	Signature	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date

☐ Client or Guardian refuses to Acknowledge Receipt: _____ _____
Signature of Therapist Date

Acknowledgement of/Agreement to Informed Consent for Treatment (version 03.07.2014)

The undersigned/the client have had the opportunity to ask any questions that the client may have about Elisa Horton, LMFT, LMHC, NCC, Inc's informed consent for treatment. By signing this informed consent the client is agreeing to adhere to all of its contents and is voluntarily choosing to enter into a therapeutic relationship with Elisa Horton, LMFT, LMHC, NCC, Inc. and may terminate services at any time.

Adult Client Name (Printed)	Date of Birth	Signature	Date
Adult Client Name (Printed)	Date of Birth	Signature	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date

Acknowledgement of/Agreement to the No Secrets Policy

The undersigned/the client have had the opportunity to ask any questions that the client may have about the No Secrets Policy. By signing this the client is agreeing to all of its contents and is voluntarily choosing to adhere to it's content.

Adult Client Name	Date of Birth	Signature	Date
Adult Client Name	Date of Birth	Signature	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date

Instructions: Please fill out the form completely. All clients seen in the counseling room with the client whose records are being requested will need to fill out this form in order for this authorization to be valid. PLEASE INITIAL THE BOXES YOU'D LIKE TO AUTHORIZE.

Authorization for Release/Exchange of Information

Name: _____
DOB: _____ SSN: _____

I (Responsible Party), _____, hereby request and authorize:

_____
(Name of person(s) or agency you'd like Elisa Horton, LMFT, LMHC, NCC, Inc. to interact with – e.g. name of your doctor)

_____
Address (e.g. the above doctor's address)

_____(_____)_____(_____)_____
City State Zip Code Phone Fax

to ☐ release or ☐ exchange medical, education, mental health, or other pertinent information from my record with Elisa Horton, LMFT, LMHC, NCC, Inc. at 901 SW Martin Downs Blvd, Ste. 317, Palm City, Fl 34990 Phone: (772) 426-9955; Fax (772) 781-8388 for the purpose of best practices and/or continuity of care of: _____ _____ (the client who's record this authorization pertains to).

The specific information to be disclosed is:

☐ Psychiatric treatment, evaluation(s) and record(s)
☐ Psychological testing and evaluations
☐ Inpatient or Outpatient Treatment Records
☐ Mental health/Counseling records/information
☐ Substance use, history and treatment records
☐ Education records, testing data, & information
☐ Medical information
☐ Rehabilitation records
☐ Police report(s)
☐ Legal information/Court order
☐ Verbal communication about checked items
☐ Other: _____

I understand this authorization is voluntary and will automatically be revoked twelve (12) months from the date of the signature, or upon termination of treatment if less than twelve (12) months from the date of signature. I understand that I have the right to refuse to sign this authorization without penalty. I further understand that I have the privilege of revoking authorization at any time, provided that I provide written notice. However, this revocation will not effect information released prior to the written revocation. This release shall be in compliance with federal regulations (42 CFR, part 2, Section 33 of Public Law 910616 as amended by Public Law 93-282) and will comply with all applicable state and local laws, rules, and regulations.

_____ _____
Signature of Client Date Signature of Witness Date

_____
Signature of Parent/Legal Guardian Date

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further re-disclosure is strictly prohibited. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

Insurance Information Form

** Full completion of this form is required and will **require** you to call your health insurance carrier to speak with a representative. This should only take about 5-10 minutes of your time but will save you from future stress and unexpected expenses! This has to be completed before our first insurance based session together. I will need to see and copy a government issued photo identification card (i.e. a driver's license) and the person seeking service's health insurance card. **

1) Who is the primary insured on this policy? _____
2) What is his/her DOB? _____
3) What is his/her address including city, state, & zip? _____
4) What is his/her phone number? _____
5) The employer/who his/her health insurance is through? _____
6) Who is the client in relation to the primary insured? ☐ self ☐ other relation: _____
   (i.e. mother, father, step-mother, guardian, etc)

Name of person obtaining the authorization: _____
Who is the authorization for? _____
Relation to the client/authorized individual: ☐ self ☐ other: _____
Date of call: _____

Begin call

7. Insurance representative's name &/or ID # that you spoke with: _____
8. "Does my plan cover outpatient mental health counseling?" ☐Yes ☐No
9. "Is Elisa Horton, LMFT, LMHC, NCC "in network" on my insurance plan for outpatient mental health services?" ☐Yes ☐No (if "no" you will need to ask "what are my out-of-network coverage benefits? Is a separate deductible?", etc – please contact me if this is the case to discuss the details).
10. "Is there an individual or family deductible to be met?" ☐No ☐Yes (amount left to be met $_____ for individual seeking services &/or $_____ for family).
    "Under what circumstance will the family deductible be charged?"
    _____
    "Is this deductible: ☐ per calendar year or ☐per plan year (between _____& _____)?"
11. "What is the copay per session ?" _____ "Or what is the co-insurance?" _____
12. "Is authorization required for outpatient mental health?" ☐Yes ☐No If yes, then "What is the authorization code or number for sessions with Elisa Horton?" #_____
13. Who is the authorization under/for? ☐ self ☐ other: _____
14. "How many sessions does that authorization number entitle the authorized individual to?" _____
15. "What is the date range the authorization is valid through?" _____ to _____
16. "Will an authorization sheet be mailed, emailed, or faxed to the provider?" ☐Yes ☐No

End call

Authorization to utilize health insurance benefits

I, _____(name of insured or authorized representative), hereby authorize _____(name of insurance carrier) to pay and hereby assign directly to Elisa Horton, LMFT, LMHC, NCC, Inc. all benefits, if any, otherwise payable to this practice for counseling services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Elisa Horton, LMFT, LMHC, NCC, Inc. will be credited to my account, in accordance with above said assignment.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ Date: _____

Authorized Signature of Subscriber

EAP Information Form

** Full completion of this form is required and will **require** you to call your EAP carrier to speak with a representative. This should only take about 5-10 minutes of your time but will save you from future stress and unexpected expenses! This has to be completed before our first EAP session together. I will need to see and copy a government issued photo identification card (i.e. a driver's license) and the authorized person's health insurance card **

1) What is the name of the employee who has the EAP coverage? _____
2) What is his/her DOB? _____
3) What is his/her address? _____
4) What is his/her phone number? _____
5) The employer/who his/her EAP is through? _____
6) Who is the client in relation to the employee with EAP coverage? ☐ self ☐ other relation: _____ _____(i.e. mother, father, step-mother, guardian, etc)

Name of person obtaining the authorization: _____
Date of call: _____

Begin call

7. EAP representative's name &/or ID # that you spoke with: _____
8. Name of the EAP company: _____
9. Is Elisa Horton, LMFT, LMHC, NCC "in network" on your EAP plan? ☐Yes ☐No
10. What is the authorization code or number for sessions with Elisa Horton? #_____
11. Who is the authorization listed under/for? _____
12. How many EAP sessions does that authorization entitle the authorized individual to? _____
13. What is the date range the authorization is valid through? _____ to _____
14. Will an authorization sheet be mailed, emailed, or faxed to the provider? ☐Yes ☐No

End call

Authorization to utilize EAP benefits

I, _____(name of insured or authorized representative), hereby authorize _____(name of EAP carrier) to pay and hereby assign directly to Elisa Horton, LMFT, LMHC, NCC, Inc all benefits, if any, otherwise payable to this practice for counseling services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any EAP benefits, when received by and paid to Elisa Horton, LMFT, LMHC, NCC, Inc will be credited to my account, in accordance with above said assignment.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ Date: _____
Authorized Signature of Subscriber

Non-Intact Family Agreement
For the divorced/separated/otherwise shared custody parent of a child receiving services.

I, _____ , am aware that my child, _____,
(name of divorced/separated/otherwise shared custody parent's name) (child's name)

has an intake appointment scheduled with you (Elisa Horton) on _____ at _____.
(date of appointment) (time of appt)

The appointment was made by _____. I understand that my child will be in continued
(name of parent/guardian initiating appt for child)

counseling with you and give my consent for you to provide counseling services to my child. I understand that there are limits to what a therapist can share with a parent with respect to a child's right to confidentiality (as listed in the Notices of Privacy Practices/HIPAA laws and Informed Consent Forms available on www.elisahorton.com). I understand that the only part of a family session can be discussed with me if I was not present is the part that pertains to my child's treatment/progress, within limits. Lastly, I acknowledge that I am bound by all service terms and conditions as outlined in the HIPAA Notice of Privacy Practices and by Elisa Horton's Informed Consent for Treatment Forms.

_____ _____
Signed by divorced/separated/otherwise shared custody parent Date

_____
Printed name of above

_____
Address to receive mail at regarding the child (please remember to include city, state, and zip)

_(_____)_____
Phone number where a message can be left regarding the child's care

_____
Email address where information can be received (it will not be confidential – please do not give an email if it is not ok that it will be non-confidential as Elisa Horton cannot guarantee email's confidentiality.

Appointment Reminders and Online Appointment Scheduling

You do not have to fill the information section of this form if you have already entered it into your biographical information online - But I do require your signature.

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.
You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit www.elisahorton.com and click "Appointments" to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system. PLEASE PRINT CLEARLY - I cannot be held accountable for illegible information!

Client's name: _____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| (letters or numbers only)

Requested password: |__|__|__|__|__|__|__|__|__|__| (letters or numbers only)
Your email address: _____
Your cell phone number: _____
Your cell phone carrier (circle one): Alltel AT&T Boost Mobile Nextel Sprint SunCom T-mobile Verizon VoiceStream Virgin Mobile Other:_____

Where would you like to receive appointment reminders? (check one)
_____ Via a text message on my cell phone (normal text message rates will apply)
_____ Via an email message to the address listed above
_____ Via an automated telephone message to my cell phone
_____ None of the above. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above or as I have noted it in the biographical form I filled out online.

Additionally, by signing below, I acknowledge that:

- **Information sent by Elisa Horton, LMFT, LMHC, NCC, Inc. can be intercepted by people other than me but that I accept this risks as self-evident (i.e. someone opens my mail, hacks my or the therapist's email or cell, reads my text message, etc.).**
- **Emails, cell phones, and Wi-Fi connections can be unsecured/unencrypted forms of communication – engaging with Elisa Horton, LMFT, LMHC, NCC, Inc. over these types of technologies puts my/our communications at risk.**
- **I am responsible for keeping my information updated with Elisa Horton, LMFT, LMHC, NCC, Inc. at all times to avoid unintended disclosure of PHI (i.e. a change in phone number or address).**
- **I can withdrawal/change my mind about these preferences in writing to Elisa Horton, LMFT, LMHC, NCC, Inc. at any time.**

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Adult Client/Guardian's Signature Date

For _____ (minor's name for if client is a minor)

Credit Card Authorization Form

Please complete the following information as per Elisa Horton LMFT, LMHC, NCC, Inc's policy. This form will be securely stored in your encrypted clinical file and may be updated upon request.

I, _____, am authorizing Elisa Horton, LMFT, LMHC, NCC, Inc. to use my credit card information to charge my credit card in the event that:

1. I do not notify her of my/my child's inability to attend a scheduled therapy appointment (no show – fees are based upon the informed consent for treatment that I signed upon initiating services)
2. I do not cancel or reschedule my/my child's appointment at least 24 hours in advance (< 24 hr CX/RS – fees are based upon the informed consent for treatment that I signed upon initiating services)
3. a check related to services provided to me/my child is returned for any reason (the amount of the check will be billed to my credit card in addition to any service fees incurred as a result by my bank or as stated in the informed consent for treatment that I signed upon initiating services whichever is less)
4. there is an outstanding balance on my/my child's account anytime after 30 days of the date(s) of service(s) billed (my card will be billed the full amount unless prior arrangements have been made in writing with Elisa Horton, LMFT, LMHC, NCC, Inc.)

By signing below I am authorizing Elisa Horton, LMFT, LMHC, NCC, Inc. to charge for scheduled appointments as described above or for my/my child's outstanding balances anytime after 30 days of the date(s) of service(s) billed. I am also agreeing to notify Elisa Horton, LMFT, LMHC, NCC, Inc as soon as possible of any change in my credit card information. In the event of a declined card – I will be asked for another credit card. If I have a question about a charge, I will notify Elisa Horton, LMFT, LMHC, NCC, Inc. within 15 days of the charge because after 30 days the charge will be assumed to be correct. Elisa Horton, LMFT, LMHC, NCC, Inc. will keep a clear record of all payments and charges – in the rare event that I have been overcharged a credit will be issued towards my next session or if I have terminated therapy it will be applied back to my credit card.

I have read and understood the Credit Card on File Agreement and authorize Elisa Horton, LMFT, LMHC, NCC, Inc. to charge my credit card as stated above.

Type of Card: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Card number: _____-_____-_____-_____

VPN/Security code (3 numbers on the back of the card by the signature line:_____

Exp. date on the card: _____/_____ (Card given must be current)

Name on the card: _____

Client's name (if different than cardholder): _____

Billing address of the card: _____

Billing city: _____ Billing zip code:_____

Email address where I'd like receipts sent: _____

Authorized signature:_____ Date: _____