Portal Form: Client Information Form

Share on Portal

About Preview

This is a preview of the form and information here will not be saved.

Preview: Client Information Form

Date:

Legal Name:

first

middle

last

suffix

Preferred Name:

optional

Pronouns:

Date of Birth:

m/d/yyyy

Address 1:

Address 2:

Zip:

zip code

City/State:

city

Time Zone:

Mobile Phone:

It is OK to send text or leave voice messages

Home Phone:

It is OK to leave voice messages

Work Phone:

It is OK to leave voice messages

Other Phone:

It is OK to leave voice messages

Administrative Sex:

Male Female

Gender Identity:

Sexual Orientation:

Race:

Add Race

Ethnicity:

Add Ethnicity

Languages:

Add Language

Smoking Status:

Marital Status:

Employment:

Religious Affiliation:

Add Religious Affiliation

Share on Portal

Portal Form: Client Insurance Form

Share on Portal

About Preview

This is a preview of the form and information here will not be saved.

Preview: Client Insurance Form

Patient: Date:

Insurance Policies

I do not have or do not want to use insurance benefits. I will be responsible for all charges related to the services rendered.

Policy Information

Insurance Company:

search for an insurance company

Member/Beneficiary ID:

Priority:

Primary

Policy Group:

leave blank if unsure

Plan Name:

leave blank if unsure

Policy Holder

Client Relationship:

Self

Insurance Card

Provide photos of the front and back of your insurance card to send to your practice. You can take a photo with your camera or upload a file.

Front of Insurance Card

Take Photo or Choose File No file chosen

Back of Insurance Card

Take Photo or Choose File No file chosen

Release of Information & Assignment of Benefits

I understand and agree to the following:

I authorize the release of information from my medical record to the insurance company or other third-party payer named above. This information shall include all information necessary to submit and process claims, such as my name, date of birth, address, medical diagnosis, and services provided to me.

If the practice has already shared information with the insurance company or other third-party payer at the time I revoke this authorization, it is too late to prevent that information from being shared.

This authorization is necessary for the practice to determine eligibility for treatments or benefits or to pay for treatments I receive, but the practice cannot condition treatment on the provision of this authorization.

This authorization shall be effective for 1 year from the date of my signature, unless I contact the practice in writing any time prior to then to revoke.

If you are using Medicare benefits, you also agree to the following: I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

In consideration of the services provided to me, I assign all benefits to the practice, if accepted, and authorize this insurance company to make payments directly to the practice and its affiliates on my behalf.

+ Add Another Policy

Acknowledgment

I have read and understood the contents of this form. All information entered by me is true and accurate, and I have only entered information about myself or an individual I am authorized to act on behalf of, such as my child. I consent to use electronic signatures, and my signature below is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.

Signed By:

Enter Your Legal Name

Draw Signature Use Typed Name

Share on Portal

Portal Form: Client History Form

Share on Portal

About Preview

This is a preview of the form and information here will not be saved.

Preview: Client History Form

Patient: Sigmund Freud, DOB 5/6/1856 Date: October 26, 2026

Why are you seeking help now?

What is happening or is different? What stressors do you have? What do you hope will be different by seeking help?

Please give more details about the issue you named above:

When did it start? How often does it happen? How does it affect your life? How have you dealt with it so far? Have you ever had thoughts of harming yourself or others? If so, when was the last time? Have you ever taken any actions toward harming yourself or others? If so, when was the last time? Have you ever been hospitalized? If so, when, where and for what concern/diagnosis?

Have you ever experienced similar or other mental health symptoms before?

If so, what was your experience like? When did it happen? Did you get help? Have ever experienced a traumatic event that continues to cause distress? Some examples of potentially traumatic experiences include emotional, physical or sexual abuse; natural disaster (e.g., flood, hurricane, tornado, earthquake); fire or explosion; accident (e.g., car/boat/train/plane crash, accident at work/home/during recreation); exposure to toxin; combat/war; captivity; injury/illness; death/dying.

Has anyone in your family ever experienced mental health or substance use issues?

If so, who was it? Did they seek help or get a diagnosis? What was it like for them? What was it like for you?

Do you have any current or prior medical issues?

If so, what was/is it? Have you seen a doctor or other healthcare professional for it? What recommendations or treatment did you have? Is there any family history of disease? Please list your primary care and other providers with phone numbers if you would like your psychotherapist to collaborate with these providers.

Are you currently taking any medications - either prescribed or over-the-counter?

If so, please list the name, dosage, how often you take it, and the prescriber for each medication. Please also list any known drug allergies.

☐ I am currently not taking any medications or supplements.

+ Medication

Do you now, or have you ever, used alcohol, tobacco, recreational drugs, or prescription medication other than as prescribed?

If so, which? When did you start, how often did/do you use, and how long did this occur? Please list each substance separately. What problems did these substances cause you? On an average day, how much time do you spend gaming, scrolling social media, or gambling? Do you often stay on devices or gamble longer than you originally intended? Do you use online activities or gambling to cope with stress, boredom, sadness, or anxiety? How does your device use or gambling affect you?

Who is in your family? What is your relationship with them like?

Please list all individuals you consider to be a part of your family. For those who are not part of your family of origin (such as significant others), please include the duration of your relationship.

What social activities and relationships do you engage in?

What important social relationships do you have? Do you belong to any social clubs or organizations? How do you like to spend your leisure time?

What spiritual practices and cultural influences are important to you?

Do you belong to a religious, faith, or spiritual community? What other cultural groups do you identify with? How do you celebrate culture and spirituality in your life?

What was life like as you were growing up, both at home and in school?

Did you meet developmental milestones on time or experience any delays? What were your friends like when you were younger? What was school like for you?

What significant educational and work/volunteer experiences have you had?

What is the highest level of education you have completed? Are you currently employed? If so, where and for how long? What other work and educational experiences have you had (such as a stay-at-home parent or semester abroad)? Are you satisfied with your current employment and education? Have you or a loved one served in military?

Do you have any current or prior legal issues?

Were you ever arrested or charged with a crime or misdemeanor? Do you have any involvement with the civil courts, such as a lawsuit or family law matter? If so, please describe them.

What strengths and abilities are you bringing to sessions? What needs or preferences do you have that will help us be successful?

What coping skills have been working for you so far? What is important to know that will help make our time more effective for you?

What else is important to know about you?

Also, some insurances require us to inquire regarding Advance Directive on file and drug allergies. Please indicate yes or no if you have an Advance Directive in place.

Share on Portal

Portal Form: Consent for Services

Horizon Behavioral Health, PLLC
16 Water Street, Suite 101, Everett, Pennsylvania, 15537
(814) 283-5535

Informed Consent for Psychotherapy

Welcome to Horizon Behavioral Health (HBH). This document contains important information about professional services and business policies. Please read it carefully and make notes of any questions you might have so that they can be discussed. When you sign this document, it will represent an agreement between you and your provider.

Psychological Services

Psychotherapy is not easily described in general statements and varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things discussed both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you many experience uncomfortable feelings like sadness, anger, guilt, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your provider will be able to offer you some first impressions of what the work is anticipated to include and a treatment plan will follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have any questions about procedures, please discuss them with your therapist whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another behavioral health professional for a second opinion or referral.

Meetings

Typically, an evaluation is conducted in one to three sessions during which time you and your provider can both decide if the therapist is the best person to provide the service you need in order

to meet your treatment goals. Sessions are usually scheduled weekly and last 55 minutes, which is consider one therapy hour. Sessions can be more frequent, as indicated and agreed upon. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation, unless you and your provider both agree that you were unable to attend due to circumstances beyond your control. If possible, your therapist will reschedule your appointment.

Professional Fees

The initial intake fee is $200 and the rate for follow up sessions are $175 (55 minute therapy sessions), $150 (45 minute therapy sessions), and $100 (30 minute therapy sessions). In addition to weekly appointments, providers will charge $200 per hour for other professional services you may need. Other services include report writing, telephone conversations lasting longer than five minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for professional time even if the provider is called to testify by another party. Because of difficulty of legal involvement, there will be an hourly charge for preparation and attendance at any legal proceeding. The rate for group psychotherapy is $50 per hour.

Billing and Payments

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. The fee for failing to contact the clinic to cancel or reschedule your appointment less than 48 hours prior to your appointment is $60. If you fail to show or contact the clinic at all, you may be charged the entire fee. If late cancellations or no shows occur repeatedly, you will be removed from our schedule. You are welcome to return to treatment when you can commit to keeping your appointments, after 30 days, pending availability.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the clinic has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information released regarding a patient's treatment is the patient's name, the nature of services provided, and the amount due.

We also require that you have a credit card on file, which will not be charged unless you request to make payment by this method or fail to settle your account in a timely manner by other means. This payment method will also be used in the event you fail to honor the cancellation policy.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have health insurance, it will usually provide

some coverage for behavioral health treatment. HBH employs a billing company to assist with insurance payments. You (not your insurance company) are responsible for full payment of charged fees. It is very important that you find out exactly what services your insurance policy covers. The billing company and your provider will make an honest effort to prepare material for your insurance.

If you have questions about your coverage, call your plan; there is typically a number on the back of your insurance card. Your therapist and other staff will be happy to provide you with information based on their experience and help you understand the information you receive from your insurance company. If it is necessary to clear confusion, the provider or billing company will be willing to call the insurance on your behalf.

Due to the rising costs of health care, insurance benefits have become increasingly complex. It is sometimes difficult to determine exactly how much coverage is available. It may be necessary to request an authorization to initiate services or an approval for more therapy sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require you to authorize your therapist to provide them with a clinical diagnosis. Sometimes additional clinical information is required such as treatment plans or summaries, or copies the entire record (although this is rare). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, HBH has no control over what they do with it once it is in their hands.

Once all the information about your insurance coverage is attained, your therapist will discuss what can be expected to be accomplished with the benefits that are available and what will happen if they run out before you feel ready to end treatment. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

Contacting Providers

Providers are often not immediately available by phone. While providers typically have office hours, they will often be with patients and unavailable to answer the phone. When unavailable, other staff or monitored voicemail will be available. Providers will make every effort to return calls on the same business day, or next business day, in the event of calls after hours, or on weekends or holidays. If you are difficult to reach, please leave a message with times you will be available. If you are unable to reach a provider and feel you cannot wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If a provider will be unavailable for an extended time, the provider will offer the name of a colleague to contact, if necessary. Please let your provider know if you prefer to communicate via electronic means and that will be discussed.

In the event your provider has an emergency and is unable to make contact with you, a colleague will reach out to you. This staff member will observe all confidentiality practices of the clinic.

Professional Records

As you are likely aware, providers are required to keep records of the professional services rendered. Because these records contain information that can be misunderstood by someone who is not a behavioral health professional, patients are generally not permitted to review them directly; however, at your request, a treatment summary can be provided in many cases. If a summary is deemed as potentially demanding to you, a summary can be sent to another behavioral health professional who is working with you, with your completion of a release of information.

Please note that we are an environmentally friendly, largely paperless practice. Whoever you authorize to receive your information will need to have a secure way to received your documents. This limits processing time and fees to you.

Confidentiality

In general, the privacy of all communications between a patient and behavioral health provider is protected by law, and information about our work can only be released to others with your written permission. We take this very seriously and make every effort to protect your privacy. However, there are exceptions, outlined below.

In most legal proceedings, you have the right to prevent the release of information regarding your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order testimony. In the event a legitimate court order is received, your provider will need to respond.

There are some situations in which providers are legally obligated to take action to protect others from harm, even if that requires revealing information about a patient's treatment. For example, if a provider believes a child or an adult who is vulnerable in some way has been or is being abused, the provider must file a report with the appropriate agency. This extends to prenatal exposure to substances of abuse.

If a provider believes a patient is a risk to themselves or others, the provider is required to take protective actions. These actions can include notifying a potential victim, contacting the police, seeking hospitalization of the patient, or contacting patient family members or others who can help provide protection.

In the event you disclose professional misconduct by another health care professional, your provider is required to make a report to the governing agency. If a professional meeting or legal hearing is held, relevant records may be released to substantiate the concerns.

These situations rarely occur and every effort will be made to fully discuss disclosures before taking action.

Parents or legal guardians of non-emancipated minors also have the right to access a patient's record when the patient is under age 18. In the event of a patient's death, the spouse, parent, or other legal guardian has the right to access the deceased patient's record.

Providers may occasionally find it helpful to consult with other professionals about a case. During a consultation, every effort will be made to protect identifying information. The consultant is also legally bound to keep the information confidential.

An additional measure we use to protect your privacy is limiting communication outside of the office. Providers and staff will not attend events at your invitation or acknowledge you in public, unless you do so first. Staff will not accept requests to connect on social media.

If you have any questions or concerns about any issues of confidentiality, please note and discuss them with your provider at your next session.

Acknowledgment

My signature on this document represents that I have received the Consent for Services form and that I understand and agree to the information therein. Further, I consent to use an electronic signature to acknowledge this agreement.

Signed By (Name & Signature):

Date Signed:

Portal Form: Emergency & Other Contacts Form

Share on Portal

About Preview

This is a preview of the form

Preview: Emergency & Other Contacts Form

Patient:
Date:

My Contacts

Name Prefix | First Name | Middle Name | Last Name | Suffix

Company

.

Contact Type

- [ ] Emergency Contact
- [ ] Guardian
- [ ] Primary Care Physician

Relationship

Phone

Mobile +

Email Address

+ Mailing Address

Save Changes Cancel

Party Responsible for Payment

Me / The Patient

Share on Portal

Portal Form: Notice of Privacy Practices

Horizon Behavioral Health, PLLC
16 Water Street, Suite 101, Everett, Pennsylvania, 15537
(814) 283-5535

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. Your provider creates a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

Staff are required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.

- Give you this notice of my legal duties and privacy practices with respect to health information.

- Follow the terms of the notice that is currently in effect.

We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in the office, and on my website.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the

patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

Psychotherapy Notes. We may keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For use in treating you.

b. For use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For use in defending providers in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

Marketing Purposes. As a providers, we will not use or disclose your PHI for marketing purposes.

Sale of PHI. As a providers, we will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

a. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

b. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

c. For health oversight activities, including audits and investigations.

d. For judicial and administrative proceedings, including responding to a court or administrative order, although our preference is to obtain an Authorization from you before doing so.

e. For law enforcement purposes, including reporting crimes occurring on my premises.

f. To coroners or medical examiners, when such individuals are performing duties authorized by law.

g. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

h. Specialized government functions, including, ensuring the proper execution of military missions and national security; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

i. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.

j. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

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

Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and may say “no” if I believe it would affect your health care.

The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

The Right to Choose How PHI is Sent to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.

The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.

The Right to Get a List of the Disclosures Made.You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost based fee for each additional request.

The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say “no” to your request, but will tell you why in writing within 60 days of receiving your request.

The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it. Please tell your provider if you would like a paper copy.

VII. HOW TO EXERCISE YOUR RIGHTS:

If you would like to request records or lodge a privacy-related complaint, please email Dr. Steinbrunner at hbhpllc@protonmail.com. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. The Practice will not retaliate against you for filing a complaint.

VIII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on January 1, 2020

Should the Practice make changes, you may obtain a revised Notice by requesting a copy from the Practice, using the information above, or by viewing a copy on the website at https://www.horizonbehavioralhealth.org

Signed By (Name and Signature): _____

Date Signed:_____

Portal Form: Payment Authorization Form

Share on Portal

About Preview

This is a preview of the form.

Preview: Payment Authorization Form

Patient: Date:

Payment Method Details

Name on Card:

Card Number:

Card Expiration:

-- --

Security Code:

Billing Address Line 1:

Billing Address Line 2:

Billing Zip:

Billing City/State:

Acknowledgment

The practice may utilize my payment methods on file for any balances, including late cancellation and no-show fees, without additional authorization.

* Patients with an active Medicaid policy at the time of scheduled service cannot be charged for no-show or cancellation fees.

Signed By: (Enter your Legal Name)

Draw Signature Use Typed Name ✖ Clear

Share on Portal

Portal Form: Psychiatric Advance Directive Information Form

This form is called a Psychiatric Advance Directive (PAD) Information Form. Your therapist, counselor, psychologist, doctor, or other health professional ("Provider") has asked you to read and sign this form. Please review the information. If you have any questions, contact your Provider.

About Psychiatric Advance Directives

A Psychiatric Advance Directive (PAD) is a legal document created by a competent individual to provide instructions for future mental health treatment or appoint an agent to make treatment decisions on their behalf. PADs are drafted when a person is well enough to consider their treatment preferences and are used when the person becomes incapable of making decisions during a mental health crisis.

Incapacity generally means the person lacks sufficient understanding or ability to make and communicate treatment decisions. If you are determined to lack this capacity, your healthcare provider must follow the instructions in your PAD or those given by your healthcare agent. They may also notify other providers of these instructions. However, they are not required to follow PAD instructions if they conflict with accepted medical standards or are contrary to your needs during an emergency.

Healthcare Agents

If you appoint a healthcare agent in your PAD, they will follow your instructions when making treatment decisions on your behalf. Once your healthcare provider determines you are incapable of making decisions, your healthcare agent will be consulted. If your healthcare provider is unavailable, the attending physician or eligible psychologist will decide when to consult your healthcare agent, and this decision must be documented in writing.

- Your healthcare agent must act as you would if you were capable.
- Your healthcare agent must do what you instruct in your PAD.
- Your healthcare agent can discuss and review treatment information with your care providers.
- You can limit your healthcare agent to making only mental health treatment decisions.
- You can tell your healthcare agent about any medications, treatments, or hospital admissions you want considered.

How to Create a PAD

This varies by state, so refer to your state's page for specific information about forms and requirements. Generally, you can create a PAD by filling out your state's provided form. If your state does not have a specific form, they should provide the criteria needed to create a valid PAD.

- You are usually required to have your PAD form witnessed, formally signed, and sometimes notarized.

You should give copies of your form to your primary care physician and mental health treatment providers, also to your healthcare agent if you assign one.

Additional information you can include in your PAD:
- a person to contact in case of a mental health crisis
- possible causes of your mental health crisis
- ways to help you avoid hospitalization
- how you generally react to hospitalization
- other relevant instructions

State-By-State Information and Links

Psychiatric Advance Directives (PADs) are relatively new legal tools that allow competent individuals to document their specific instructions or preferences for future mental health treatment. These directives can be used to plan for situations where a person may lose the capacity to give or withhold informed consent during acute episodes of psychiatric illness. Nearly all states allow advance directives for healthcare, which can be used to direct some forms of psychiatric treatment. In the past decade, twenty-five states have adopted specific statutes for psychiatric advance directives.

The National Resource Center on Psychiatric Advance Directives has more information on state-by-state requirements. State by State Info

After Creating a PAD

Give a copy to your mental healthcare provider to include in your medical record. Additionally, consider keeping a copy of your PAD or your PAD registration card with you at all times.

Ending a PAD

While ending a PAD varies by state, you can change or end your PAD at any time you are considered capable. For detailed information on how to revoke or modify your PAD, review your state's statutes.

Acknowledgment

My signature on this document represents that I have received the Psychiatric Advance Directives Information form and that I have reviewed the information therein. Further, I consent to use an electronic signature to acknowledge my receipt of the information.

Signed By (Name and Signature):

Date Signed:

Patient Health Questionnaire-9

The Patient Health Questionnaire-9 (PHQ-9) is a brief (up to 10 questions) tool used to assess how bothered you have been by a variety of common problems. Completing this questionnaire should take less than 5 minutes.

Instructions: For each question, think about how bothered you have been by the problem **over the last two weeks.**

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Little interest or pleasure in doing things

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Feeling down, depressed, or hopeless

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Trouble falling or staying asleep, or sleeping too much

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Feeling tired or having little energy

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Poor appetite or overeating

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Feeling bad about yourself — or that you are a failure or have let yourself or your family down

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Trouble concentrating on things, such as reading the newspaper or watching television

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Thoughts that you would be better off dead or of hurting yourself in some way

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

Over the **last 2 weeks**, how often have you been bothered by the following problems?

Thoughts that you would be better off dead or of hurting yourself in some way

- ❑ Not at all
- ❑ Several days
- ❑ More than half the days
- ❑ Nearly every day

How **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ❑ Not difficult at all
- ❑ Somewhat difficult
- ❑ Very difficult
- ❑ Extremely difficult

Horizon
BEHAVIORAL HEALTH, PLLC

(814) 283-5535
16 Water Street, Suite 101; Everett, PA 15537

Thank you for trusting your behavioral health care to our team!

We would like to share the following important policies that we adhere to, and ask you to adhere to, in order to provide the best care possible to as many people as possible.

1. **Late cancellations and no-show guidelines**. If you have more than one no-show or same day cancellation, you may be charged a fee and/or be removed from the schedule for 30 days. We will try to notify you, if staffing allows, but may not always be able to. Please monitor your patient portal or call the office for upcoming appointments, especially if you have missed any appointments. We welcome and encourage you to return to services after 30 days if you are able to commit to care at that time. It is your responsibility to call and schedule after the 30 days. You may also call daily or weekly to see if your provider has any same day openings.

This policy exists because we always have people waiting to begin services and when appointments go unused, people go without care.

2. **Requirements for telehealth appointments.** In order to participate in a telehealth session, you need to be in a quiet and private space, relatively free from distractions. You cannot be driving a car or riding in a car as you must be in a stationary location and share your current address with your provider. You must be present in the state you live in; in rare occasions providers are licensed in other states, but this must have been inquired about and arranged well in advance of your appointment. Please have your DoxyLink or SecureVideo link, or patient portal on TherapyNotes prepared and ready to go 5 minutes prior to your appointment with audio and video ready.

These requirements are for your safety, most insurances require them, and to uphold our professional ethics/licensure standards.

3. **Keep your information up to date.** Ensure your contact information such as phone number, email address, and address are current. Share and update your insurance information

when there are any changes. If your insurance lapses, you will be billed for the services you received. If your insurance changes and we do not have the insurance information and verify it, we cannot guarantee that we will be able to bill/back bill your services and you will be charged for them.

By signing below, you acknowledge receipt, understanding, and agreement with these procedures.

SUBJECT: Non-Discrimination in Services Policy Statement

TO: Patients/Clients/Residents/Parents and all applicable

FROM: Peggy V Steinbrunner, PsyD

Admissions, the provisions of services, and referrals of clients shall be made without regard to race (to include hair type, hair texture, or hair style), color, religious creed (to include all aspects of religious observances and practice, as well as belief), disability, ancestry, national origin (including Limited English Proficiency), age (40 and over), or sex (to include pregnancy status, childbirth status, breastfeeding status, sex assigned at birth.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and/or their guardian) who believes they have been discriminated against, may file a complaint of discrimination with:

Facility Contact Information
Horizon Behavioral Health, PLLC
16 Water St, Ste 101
Everett, PA 15537
8142835535
drs@horizonbehavioralhealth.org

Office for Civil Rights
U.S. Department of Health and Human Services
Centralized Case Management Operations
200 Independence Avenue, S.W.
Room 509 HHH Bldg
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
TDD: (800) 537-7697
https://www.hhs.gov/ocr/complaints
Email: ocrcomplaint@hhs.gov
(Within 180 days from the date of incident)

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
P.O. Box 2675 Harrisburg, PA 17120
Inquiries: (717) 787-1127
Email: RA-PWBEOAO@pa.gov
(Within 90 days from the date of incident)

Pennsylvania Human Relations Commission
333 Market Street, 8th Floor
Harrisburg, PA 17101
https://www.phrc.pa.gov/Complaints/Pages/How-to-File-a-Complaint.aspx
Inquiries: (717) 787-4410
TTY users only: (717) 787-7279
(Within 180 days from the date of incident)

SUBJECT: Non-Discrimination in Services Policy Statement

TO: Patients/Clients/Residents/Parents and all applicable

FROM: PEGGY HOFFMAN, PsyD  7/1/2026

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Facility Contact Information
HORIZON BEHAVIORAL HEALTH, PLLC
16 WATER ST SUITE 101 EVERETT PA, 15537
Tel.: (814) 283 5535
Fax: (814) 690 1869
Email: admin@horizonbehavioralhealth.org

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
P.O. Box 2675 Harrisburg, PA 17120
Inquiries: (717) 787-1127
Email: RA-PWBEOAO@pa.gov
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Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

• Patient medical records

• Medical images

• Live two-way audio and video

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used and that such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care, more efficient medical evaluation and management, obtaining expertise of a distant specialist, and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, poor resolution, delays in care due to equipment failures or deficiencies, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections or other factors are not adequate for the situation.
5. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
6. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
7. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
8. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
9. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

10. I understand that I need to have a secure internet connection, private and quiet place to sit for my appointment, and a webcam or smartphone for video feed.
11. I agree to provide current/ accurate demographics (address, phone number) and emergency contacts in the event of loss of connection or in case the emergency contact needs information to lessen the risk of harm if there is an imminent safety concern for you or the public.
12. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient Acknowledgment of Crisis Contact Information

Your Safety is Our Priority In the event of a mental health crisis or emergency, we want to ensure that you have the resources you need to stay safe and receive immediate support.

Please keep the following crisis contact information in a place that is easy for you to access:

📞 Crisis Contact Numbers

National Suicide & Crisis Lifeline (24/7): Call or Text 988

Crisis Text Line: Text **HELLO** to **741741**

Emergency Services: Call **911** or go to your nearest emergency room if you are in immediate danger.

Local Crisis Line (County and phone number):

Bedford/Somerset- (866) 611-6467

Blair- (814) 889-2141 Choose option 1

Monongalia- (800) 232-0020

Jefferson/Berkeley- (855) 807-1258

For other counties in WV, please use the national line or HELP4WV offers 24/7 support via call, text, or chat at 1-844-HELP4WV.

🖊 Patient Acknowledgment

I acknowledge that I have received the above crisis contact information. I understand that this information is available to support me in case of an emotional or behavioral health crisis. I have been given the opportunity to ask questions about these resources.

Portal Form: Medication management: Additional Information Required

Actions

About Medication management: Additional Information Required

This information is required before scheduling all medication management appointments. If there are any changes to the information provided, please update it as soon as possible to avoid delays in receiving your medication

Sharing on the Portal: Shareable on Demand

Staff Access: Administrative

Medication management: Additional Information Required

Patient: Patient Name , DOB Patient DOB

Date: Date Submitted

This is a preview of the form and information here will not be saved.

Please provide the name of your PCP:

Please provide the phone number for your PCP:

Please provide your preferred pharmacy to include an address or approximate location (i.e., Rite Aid on Main Street, Everett, PA):

Please provide the phone number to your preferred pharmacy:

Practice Acknowledgment

☐ **Sign This Form:** I, Practice User, have reviewed this form on Date.

Copy Form Share on Portal