HORN AND ASSOCIATES IN REHABILITATION, PLLC

2412 Greatstone Point
Lexington, Kentucky 40504
Phone (859) 224-4081

www.horntherapy.com

4127 Todds Road
Lexington, KY 40509
Fax (859) 224-4082

2024 ABI Client Information

Client Name:_____Date of Birth:_____SSN:_____

Address:_____City:_____State:_____Zip Code:_____

Primary Phone:_____Secondary Phone:_____

(Please indicate identifying information - parent/caregiver number, cell or landline, etc.)

Client Email Address:_____

Other Email Address:_____

Emergency Contact Name:_____Phone Number:_____

Medicaid Number:_____

Guardian Information

Guardian Name:_____

Address:_____City:_____State:_____Zip Code:_____

Primary Phone:_____Secondary Phone:_____

Guardian Email Address:_____

Case Manager Information

Case Manager Name:_____Case Manager Company:_____

Primary Phone:_____Secondary Phone:_____

Case Manager Email Address:_____

Please notify Horn and Associates in Rehabilitation, PLLC, of any changes regarding this information.

Printed Name:_____

Client or Custodial Parent/Legal Guardian Signature:_____Date:_____

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2024 CONSENT AND PERMISSION FOR PSYCHOLOGICAL SERVICES AND/OR TREATMENT

Client Name:_____Date of Birth:_____

I understand that Horn and Associates in Rehabilitation, PLLC is providing mental health assessment and treatment services to me. I understand that there are no certain outcomes from these services and that individual experiences with treatment may vary. In giving consent to provide these services to me, I am aware that Horn and Associates in Rehabilitation, PLLC has a duty to protect my confidentiality except where the law requires disclosure of certain information. There are several exceptions in which confidentiality cannot be assured.

Duties to report include:

- A duty to report the abuse or neglect of a dependent adult and/or domestic violence offenses to the Department of Community Based Services
- A duty to report any instances of child neglect, exploitation, or abuse to the Department of Community Based Services and/or the police
- A duty to report any threats against persons to the intended victim and the police
- A duty to release information to agencies or persons with a need to know when a client is in need of hospitalization

When a client introduces personal mental health or substance abuse issues in court proceedings, confidentiality is then waived by the client.

Understanding all of the above possible exceptions of confidentiality regarding information about my mental health condition and treatment, I give consent to Horn and Associates in Rehabilitation, PLLC and its clinicians to provide assessment and treatment services to me.

Printed Name:_____

Client or Parent/Legal Guardian Signature:_____Date:_____

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2024 ABI Release of Information / Consent to Treatment

Client Name:_____Date of Birth:_____

I hereby authorize Horn and Associates in Rehabilitation, PLLC, to **release** any information including the diagnosis, records, evaluation rendered to me, and any other information to establish and maintain good care.

Initials are required to disclose privileged information:_____Psychological Records_____Social Service Records

This information may be released to and from (2-way release):
Insurance: **YES___X___**
Physician: **YES_____NO_____**
Physician Name:_____
Physical Address:_____
Physician Phone Number:_____

List additional people you choose to have access to this information (e.g., Case Manager, house staff, family members, caregivers, health care professionals)

Name:_____Relationship:Case Manager
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship: _____

I, or custodial parent/legal guardian, give permission for **Horn and Associates in Rehabilitation, PLLC**, to administer and interpret assessments and/or testing measurements, and/or initiate therapy, and/or seek emergency medical treatment if required.

CONDITIONS
- The patient or legal parent/guardian agrees to authorize the above-named individuals/organization to access his/her confidential health information only for the purposes listed above.
- The information authorized to be released will not be covered under the federal privacy laws.
- The patient or legal parent/guardian agrees that any sharing of confidential health information with individuals/organization listed above may be mailed, faxed, electronically sent and/or hand delivered.
- The patient or legal parent/guardian is voluntarily signing this authorization.
- The patient or legal guardian/parent reserves the right to refuse to sign this authorization.
- The patient or legal guardian/parent reserves the right to revoke this authorization at any time. The revocation must be in writing.
- This authorization will be maintained by Horn andAssociates in Rehabilitation, PLLC, for a period of twelve (12) months.

Through my execution of this authorization, I represent that I have legal authority to authorize the foregoing and agree to hold Horn and Associates in Rehabilitation, PLLC, harmless and indemnify from and against any and all losses and/or claims they may suffer by reasons of breach of the foregoing representation.

I have read, reviewed, and agree with: Horn and Associates in Rehabilitation, PLLC *Notice of Privacy Practices* and *Disclosure Against Surprise Billing*. A copy of these will be given upon request.

Printed Name:_____

Client or Custodial Parent/Legal Guardian Signature:_____Date:_____

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2024 CONSENT TO TREAT USING TELEHEALTH

I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me via telehealth over secure video conferencing platform.

I understand that the laws that protect privacy and the confidentiality of my medical information also apply to telehealth or teletherapy.

I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

I understand that there are potential risks involving technology, including but not limited to: Internet interruptions and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.

I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my user name and password and not share these with another person. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation.

I understand that my health care provider or I can discontinue the telehealth/teletherapy services if it is felt that this type of service delivery does not benefit my needs.

I have read and understand the information provided above regarding telehealth or teletherapy, have discussed it with my health care provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth or teletherapy in my care."

Client Name:_____Date of Birth:_____

Email Address:_____ Phone Number:_____

Emergency Contact (Name and Phone Number):_____

Client or Legal Guardian Signature:_____ Date:_____

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2024 Authorization for Student Observation and Clinical Practice

Client Name:_____Date of Birth:_____

Horn and Associates in Rehabilitation, PLLC is associated with clinical education programs related to careers in therapy (i.e., Occupational Therapy, Speech Therapy, Physical Therapy, Psychology, Social Work). Horn and Associates in Rehabilitation, PLLC provides opportunities for these students to gain observational and hands-on experience in clinical practice under direct therapist supervision.

I agree to the supervised participation of health care learners in my care. I understand my patient records will be held in strict confidentiality and will not be disclosed outside of the office. I understand I have the right to revoke this consent at any time.

Printed Name:_____

Client or Custodial Parent/Legal Guardian Signature:_____Date:_____

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2024 Consent to Leave Voicemail and/or Email

Client Name:_____Date of Birth:_____

Horn and Associates in Rehabilitation, PLLC, staff may contact you by telephone and/or email you with information such as appointment times, insurance, payment, diagnosis, records, examinations rendered to you and any other information soon your voicemail and/or email with your consent.

By signing this "Consent to Leave Voicemail and/or Email," you consent to Horn and Associates in Rehabilitation, PLLC, staff to leave messages and/or email detailed medical information to the phone number(s) and email(s) below. This information may include, but not limited to, demographic information (partial or full name, date of birth, address, etc.), billing information, and medical information (diagnosis, records, evaluation results, etc.).

○ Home Phone:_____

○ Cell Phone:_____

○ Guardian Phone:_____

○ Email Address(s):_____

_____

○ Do not leave any information on any phone number

○ Do not leave any information on any email address

I understand that Horn and Associates in Rehabilitation, PLLC, cannot require me to sign this consent form in order to receive treatment. I understand that I have the right to revoke this consent at any time. This consent is valid for a period of 12 months unless otherwise revoked. A copy of this consent form will be provided upon request.

Printed Name:_____

Client or Custodial Parent/Legal Guardian Signature:_____Date:_____

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2024 ABI Client Misc. Notes

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