HORN AND ASSOCIATES IN REHABILITATION, PLLC

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

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

www.horntherapy.com

Today's date:_____

1. Patient Information

Client Name: _____Date of Birth:_____Gender:_____

Address:_____

Phone:_____Email:_____

Occupation:_____Employer:_____

2. Legal Guardian (if applicable)

Guardian Name:_____Relationship:_____

Phone:_____Email:_____

Address (if different from above):_____

☐ Guardian is also primary contact (person we should contact regarding scheduling/communication)

3. Guarantor (Person Responsible for Payment)

☐ Patient ☐ Legal Guardian ☐ Other

(If other): Guarantor Name: _____ Relationship: _____

Phone:_____Email:_____

Address (if different from above):_____

☐ Guarantor is also primary contact (person we should contact regarding scheduling/communication)

4. Insurance Policy Holder Information

Primary Insurance Company and Policy Number:_____

Policy Holder Name and SSN:_____

Secondary Insurance Company and Policy Number:_____

Policy Holder Name and SSN:_____

5. Emergency Contact

☐ Legal Guardian ☐ Guarantor ☐ Other

(If other): Name: _____ Relationship: _____

Phone:_____Email:_____

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2026 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:_____

Physician Address:_____

Physician Phone Number:_____

List any additional people you choose to have access to this information (e.g., other family members, caregivers, health care professionals, teachers, schools)

Name:_____Relationship:_____

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.

I agree to the supervised participation of health care learners in my care (e.g., resident students, therapy students, graduate students, other clinical students, etc.) I understand my patient records will be held in strict confidentiality and will not be discussed outside the office._____**(Initials)**

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.

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 when applicable.____**(Initials)**

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._____**(Initials)**

Printed Name:_____

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

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2026 Consent to Leave Voicemail and/or Email

Client Name:_____ Date of Birth:_____

Horn and Associates in Rehabilitation, PLLC, staff may contact you be telephone and/or email you with information such as appointment times, insurance, payment, diagnosis, records, examinations rendered to you, and any other information to 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 emails below. This information may include, but not limited to, demographic information, billing information, and medical information.

☐ Phone Number(s):_____

☐ Email Address(es):_____

☐ 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 form will be provided upon request.

Printed Name:_____

Client or Parent/Legal Guardian Signature:_____ Date:_____

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2026 OFFICE TERMS AND CONDITIONS

Client Name:_____Date of Birth:_____

Thank you for choosing us for your speech/language, occupational, physical therapy, and/or psychological needs. We are committed to providing you with quality and affordable services. Our office policies are outlined below. Please read, ask us any questions, initial, and sign in the space provided. A copy will be provided to you upon request.

FINANCIAL POLICY

We are happy to send claims to insurance but please keep in mind professional services are rendered and charged to you or the patient and not to the insurance company. If our services are out of network for your insurance, we will be glad to provide you with documentation so you can send claims to your insurance company if you choose.

All patients must complete paperwork and consent forms before seeing the provider. We must obtain a copy of your driver's license/government-issued photographic identification and current valid proof of insurance. **Our office does a courtesy benefit check before your first appointment and at the beginning of the year. A member of the front office will send the primary email address on file your benefit information and estimated out-of-pocket cost. You are responsible for knowing your benefits.** Families are responsible for keeping track of the number of visits, or when and what type of authorization/precertification is necessary. The number of visits and payment of all claims is your responsibility, although we do try to track them as well. _____**(Initials)**

Please remember that precertification and/or authorization is no guarantee of payment from your insurance company. Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. We are happy to help you with additional information your insurance company may need to assist in claim payment; however, our office will not enter into a dispute with your insurance company over a claim. If there is no insurance payment activity after 60 days, we will ask for your payment and, of course, reimburse you if your insurance company later pays. _____**(Initials)**

Patient responsibility payments (copays, deductibles, coinsurance, and all outstanding balances) are due at the time of service. Our office accepts cash, checks, MasterCard, Visa, and Discover. **There will be a 3% fee for credit card transactions.** Our preference is to have a credit card or electronic check on file, which will be charged at time of billing, typically within 24-48 hours of the visit. Electronic checks and HSA/FSA cards are not subject to the fee. If you prefer to pay by check/cash, please make arrangements with office staff. If payments have not been made for more than 2 consecutive sessions, without arrangements made with office staff, services will be put on hold until payments are settled. _____**(Initials)**

It is your responsibility to notify our office immediately of any changes in your insurance. Failure to do so may result in your claims being denied and becoming patient responsibility. _____**(Initials)**

Additional documentation (i.e., disability reports/questionnaires, school updates, school conferences, 504 plans, etc.) and extended phone conversations will be provided based on a time-based fee and will be the responsibility of the patient. ___**(Initials)**

ATTENDANCE POLICY

Consistency in attendance to therapy is essential to making and maintaining progress.

Attendance: Regular attendance is expected for therapy. If attendance falls below 75%, you may lose your regularly scheduled therapy time. If you miss more than 3 sessions without 24-hour notice, you may be discharged from therapy services. _____**(Initials)**

Timeliness: If you arrive late for your session, the session may be canceled. Many sessions are scheduled for 30 minutes; if you are 10 minutes late to a session, valuable time is lost, and we are often unable to accommodate. Arriving more than 10 minutes late to a session without prior notification may qualify as a no-show. _____(**Initials)**

Missed Visit Fee: We realize there may be circumstances that require you to cancel your appointment. When these situations occur, please notify the office at least 24 hours prior to your scheduled appointment. With this notice, we may be better able to reschedule your therapy time and/or accommodate others waiting for therapy. Cancelation

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without 24-hour notice will be assessed a $48.00 cancellation fee. If you cancel more than one therapy session with different therapists within the same day and without 24-hour notice, this $48.00 fee will be assessed for each session missed. We understand emergencies do arise; in these situations, notifications are still expected. Emergency situations will be taken into consideration when assessing the cancelation fee. Messages may be left after hours through our voicemail system or email. _____**(Initials)**

SICK POLICY

Please respect the health and wellness of all our clients, staff, and therapists. We expect you to be fever free and symptom free from illness for at least 24 hours to attend therapy sessions. If you have any of the following symptoms, please notify our office immediately: fever, cough, excessive fatigue, or flu-like symptoms.
_____**(Initials)**

I understand that I am responsible for any charges not paid by my insurance coverage and I accept responsibility for any collection costs, attorney fees, and any other cost incurred that may result from nonpayment. I understand and agree to the above terms and conditions. I authorize my insurance company to pay my claims directly to Horn and Associates in Rehabilitation, PLLC.

_____
Printed Name of Client or Parent/Guardian

_____ _____
Client or Parent/Guardian Signature Date

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2026 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 toprovide assessment and treatment services to me.

Printed Name:_____

Client or Parent/Legal Guardian Signature:_____ Date:_____