GENERAL INTAKE INFORMATION

Client(s) Name : _____ Date of Birth: _____ Gender: M F

Client(s) Name (couples) : _____ Date of Birth: _____ Gender: M F

School/Work: _____ _____

Client Information [for adults] or Adult 1 [minors]	Adult 2 [Guardian or Emergency Contact]
_____	_____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____
Email: _____	Email: _____
Permission to contact: Phone ___ Email ____	Permission to contact: Phone ___ Email ____
Current Occupation: _____	Current Occupation: _____
Relationship: _____	Relationship: _____
Household members [Names, ages, relationship to client]	**Household members [Names, ages, relationship to client]**
_____	_____

If there are court papers regarding custody, the most recent temporary or final orders has been provided to our office.
_____[sign]

Briefly describe the reasons why you are seeking counseling: _____

_____

Referral Source: _____

Describe any past treatment with names of therapists and dates: _____

_____

May we contact them? If yes, please ask for a consent form to fill out.

Main (940)222-8703 // Fax (940)239-9867
www.acorncounseling.services
1430 Robinson Road, #430
Corinth, Texas 76210

Christy Graham, M.A. Licensed Professional Counselor Supervisor #16563, Registered Play Therapist Supervisor
Ashley Barkley, M.A. Licensed Professional Counselor #70694
Amy Glover, M.A. Licensed Professional Counselor Intern Supervised by Sharon Beam, LPC-S #77763
Stephanie Mouser, M.A. Licensed Professional Counselor Intern Supervised by Monya Crow, LPC-S #80693
Dr. Pam Rinn, Ph.D. LMFT Associate #202930

Services Agreement

This document contains important information about our professional services and business policies. We are agreeing to accept you as a client provided you accept the terms of this Agreement. This Agreement contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI (personal health information) for treatment, payment and healthcare operations. This Notice of Privacy Practices is attached to this agreement. Although the documents are long and sometimes complex, it is important that you read them carefully. The privacy of your information is important. Please discuss any questions you may have about the procedures.

Business Associates

Acorn Counseling Education Services contracts with various email and technical providers. We are not responsible for lost appointments due to technical difficulties on the parts of these providers. These providers have assured us of the privacy of all communications and have signed Business Associate Agreements to abide by HIPAA and HITECH laws. Even so, be aware that cell phones and other communication techniques can be monitored by third parties without permission. All interns are professionals who have completed their education and received a provisional license but need more experience under supervision. Our provisionally licensed counselors receive direct site-supervision from Christy Graham and the clients benefit from a mixture of the latest research [from the intern] and over 15 years of experience [from Christy]. All abide by the same strict confidentiality rules. If there are any concerns, please bring them to Christy Graham or their clinical supervisor as soon as possible. We also have other business partners, all of whom are required to sign BAA's to safeguard your privacy.

PLEASE INITIAL HERE_____

Treatment Philosophy

This practice focuses on women, children and families. With adults, we use cognitive behavioral therapy that includes homework. With couples, we use the highly researched Gottman Method Couples Therapy. With children and families, a combination of art, play and cognitive behavioral therapy will be utilized to assist in each member of the family communicating their view point to the other. Parents will be taught skills and given advice, but they are responsible for informing us accurately about the environment and their goals for treatment. With all clients, the adults will communicate their goals to us and we will work out a treatment plan depending on the unique circumstances and characteristics of the family. All members of the treatment paradigm are encouraged to take part in this process in an ongoing manner.

Counseling is a healing process and as such follows unique paths for each individual. There are risks and benefits in this process. At times, a client may regress during treatment. At times, progress will appear to be a simple growth curve. Please talk with me if you have any questions or notice any concerns.

Treatment Relationship

Our relationship is professional. It involves deeply personal information and connections, but it must remain professional. Therefore, no other relationship outside of therapy is allowed. Please do not bring gifts. If there are any questions regarding this, please ask. If one of us see you or a family member in the community, understand we will not acknowledge you but you may say hello. This is for your privacy. Therapy is your information to share, not ours.

Appointments

Most appointments are 45-50 minutes in length. The initial session is focused on history, answering questions, and preliminary treatment planning. In treating children, this session is reserved for the primary caregivers only, preferably both parents.
PLEASE INITIAL HERE_____
In high conflict custody or divorce cases, both parents are encouraged to have contact with me within the first few weeks of care. Phone appointments are available for those parties that are not in Denton. **PLEASE INITIAL HERE_____**
Please make appointments and reschedule with at least 24 hours' notice to avoid rescheduling fees [$75], which are automatically processed through our billing system. **PLEASE INITIAL HERE_____**
If you have an emergency, please call the Denton County Hotline at 1-800-762-0157 or 911. **PLEASE INITIAL HERE_____**
The number and frequency of appointments can vary, but to develop a good working relationship, it will be necessary to make 4 weekly appointments at the outset. After that, a working treatment plan will be developed based on the progress made and the goals of treatment.
PLEASE INITIAL HERE_____

Court Involved Therapy

If either party signs releases for their attorney, all relevant parties will sign releases and attorneys will be communicated with in tandem unless in conflict with state board rules or HIPAA Compliance Rules.
PLEASE INITIAL HERE_____
Clinicians assume that confidentiality is waived if subpoenaed. A release of information may be required.
PLEASE INITIAL HERE_____

Termination of Treatment

At the end of treatment, we will have a blessings session. At this session, we will talk about follow up recommendations, goals accomplished, and any issues that you have. Please notify me if you have decided to end treatment, so that we can have a blessings session. This will allow me to learn from you as well. If I am unable to continue services for any reason, a counselor at Acorn will be provided to transition you to an appropriate provider. **PLEASE INITIAL HERE_____**

Therapy can be terminated for any reason, at any time and by either party. We consider you to no longer be a client if 1 month has passed since our last session/contact.

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If at some point, we become unable to continue therapy, you will be provided with a professional who can refer you to a new therapist, terminate treatment, or assist with your ongoing goals. By entering into this agreement, you agree to have your file transferred to this provider at that point in order assist in your treatment.

PLEASE INITIAL HERE_____

Social Media Policy

Acorn manages and maintains several public media profiles: Facebook, LinkedIn, Twitter and Pinterest to name a few. While this is a primary way we educate our community, and we hope our clients and their families connect to us through this, they are not private mediums. Please contact us through our client portal to speak with us about treatment issues. Our relationship is professional, so please connect to our professional profiles on LinkedIn, and follow our Facebook Page, Twitter and Pinterest, but do not friend us on Facebook. If you have any questions about our social media policy, please ask me.

Professional Fees*

Individual/Family/ Consultations	Provisionally License Professionals: $100 LPC/LMFT/LCSW ACP: $125 Specialty Licensed Professionals [Supervisors or RPT]: $145 Add on fee for under 12- $10
Group	$25 per session per person
Testing	$25 per client, covers up to 5 persons reporting
Reports	$100 per hour
Supervision	$75 per session
Rescheduling Fee	$100 automatically processed through billing software
Practicum Student	$20 per session
Court	Retainer of $1500 covers 3 hours in court

Cost/session: _____ Financially Responsible Party: _____ Date: _____

*Providers are encouraged to offer discounts for particular populations/times that are difficult to schedule clients.

Types of Services Desired

We offer many different kinds of services—some are counseling and therapeutic, some are educational in nature. If you ever feel pressured or uncomfortable, please let us know. These services are NOT therapeutic, but educational in nature. While we still hold your confidentiality in high regard, these activities do not fall under federal or state guidelines for therapeutic services. You will need to sign up for these separately by filling out a simple card. We will have the person in charge of the program contact you.

_____ Christian Evidence Based Counseling _____ Evidence Based Counseling

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Client Rights

1. You have the right to request where and how we contact you: Home, work, cell phone/email [remember these are open mediums], or in some other way. By providing the number, you agree we can use it.
2. You have the right to release your medical records: Written authorization to release records to others, right to revoke your release [in writing]. If however, I have already sent the information based on the previous authorization, this will only be valid for the future.
3. You have the right to inspect and copy your medical billing records: I have the right to deny this request or to bill for fees incurred.
4. You have the right to add information or amend your medical records: After reviewing your records, you have 7 days to decide if you want to amend them. I may deny this request, in which case you can file a disagreement statement, which will be filed with our response in the record. The request must be in writing.
5. You have the right to an accounting of disclosures for 6 years from the effective date. The exceptions to this are disclosures for treatment, payment or healthcare operations, disclosures pursuant to a signed release, disclosures made to the client, or disclosures for national security or law enforcement.
6. You have the right to request restrictions on uses and disclosures of your healthcare information: These must be in writing and I do not have to agree.
7. You have the right to complain. If you have a problem, please contact a member of this office. If you are not satisfied, contact the US Department of Health and Human Services and there will be no retaliation.
8. You have the right to receive changes in policy. You may request future changes. Christy Graham is the privacy officer, you may contact her with any questions/suggestions.

COMPLAINTS

Please address any complaints to the therapist directly or to Christy Graham, the president of Acorn Counseling Education Services. If this person is unable to provide a solution, it is your right to address complaints to the State Board.

Texas State Board of Examiners of Professional Counselors
Texas Department of State Health Services MC-1982
1100 West 49th Street
Austin, Texas 78756-3183, USA

E-mail: lpc@dshs.state.tx.us
Telephone: (512) 834-6658
Fax: (512)834-6677

Website: http://www.dshs.state.tx.us/counselor

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: 12/2003

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

Acorn CES holds your confidentiality in the highest regard, from your identity to the information you offer in session. All client information is protected under both state and federal confidentiality laws. The HIPAA Security Officer and HIPAA Breach Officer is Christy Graham.

THE MOST SECURE WAY TO CONTACT OUR THERAPISTS IS VIA OUR ENCRYPTED CLIENT PORTAL OR FACE TO FACE. However, you may choose to call, or email, but these are not private means of communication. If you choose to contact us in an non-secure way, you accept liability for any breaches that may occur.

PLEASE INITIAL HERE_____

If the client is a child, the child has the right to confidential sessions and guardians have rights to information about their treatment. In balancing these rights, the therapist will use discretion as to how much and how specific to be about what occurs in session. If this is a co-parenting situation, information given by one parent will be private unless there is a need to coordinate treatment. Use of the hour will be focused on the child, but may include consultation with one or both of the parents at the therapists discretion. Concerns should be discussed with the therapist.

PLEASE INITIAL HERE_____

Specific information pertaining to your case will not be released to anyone except for specific billing purposes or court orders relating to a criminal case or investigation. There are certain limitations to confidentiality; some of which are required by law and others are required by the professional ethics codes. Please be aware of the following exceptions to privileged communications:

i) Any evidence or reason to believe that a situation where a child, elderly, or person with a disability is being abused and/or neglected exists. By law, this information must be reported to the Texas Department of Protective and Regulatory Services or other governing body, such as a court.

ii) Any probability of physical harm to self or others. Protection from physical injury takes precedence over confidentiality. Therefore, if an individual intends to take harmful, dangerous, or criminal action against self or other, we believe it is the therapist's duty to report such action or intent to the authorities.

iii) If subpoenaed by a court, this may involve providing the court with verbal testimony and/or records such as clinical notes, tapes, letters, testing, and ledgers.

iv) Use and disclosure of protected health information is for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

v) Treatment: Healthcare information will be disclosed to provide, manage, and/or coordinate care. There are times when we may engage in peer consultation. At that time your identity may be concealed. If a referral is needed, information will be shared to assist in coordination or continuity of services.

vi) Payment: Healthcare information will be disclosed to the insurance company only if you fill out the information on Therapy Appointment. It is your responsibility to enter the information accurately. Our software will automatically send information on your payments to the insurance provider and they will determine your out-of-network benefits.

vii) Healthcare Operations: Healthcare information may be disclosed to review treatment procedures and business activities, certification, staff training, and compliance and licensing activities. At this time, identifying information may be removed. viii) Confidentiality in groups is limited by their nature.

ix) Any business associate will follow the same practices the therapist has agreed to.

I understand that the encrypted client portal is the most confidential way to communicate with us. Any other communication, aside from face to face interactions, implies authorization. I authorize email/phone communication between ourselves and the therapist by communicating via email/cell phone and by providing our email address/cell phone number to the therapist. I can revoke this consent via email or written letter. Emails/voicemails are run on HIPAA compliant systems. However, mistakes can be made with these types of systems.

_____ _____

Adult Client **Date**

Minor Clients

□I affirm that I am the legal guardian of _____ and hereby grant permission for my child to participate in counseling/related services with this therapist. I understand that all information pertaining to services shall remain completely confidential except in those cases where confidentiality is limited. The limits of confidentiality, as prescribed by Texas Law and HIPAA, have been explained to me. I further understand that any release of information concerning our services shall occur only with our written consent, except in previously explained cases. I have provided legal proof of guardianship, if necessary, and contact information for other parents or guardians as applicable to our situation.

PLEASE INITIAL HERE. _____

□I have provided the most updated custody documentation that is available and pertains to this child.

PLEASE INITIAL HERE. _____

_____ _____

Parent or Guardian **Date**

_____ _____

Parent or Guardian **Date**

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