



Christy Graham, M.A. Licensed Professional Counselor Supervisor #16563,
Registered Play Therapist Supervisor
Dr. Pam Rinn, Ph.D. Licensed Marriage and Family Therapist #202930

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.

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. I am 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. Acorn also contracts with RingCentral for an encrypted telehealth platform. I also have other business partners, all of whom are required to sign BAA's to safeguard your privacy. You may find a Disclosure of General Business Relationships online.

PLEASE INITIAL HERE _____

TeleMental Health Defined:

TeleMental health means the remote delivery of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of services delivery.

Limitations of the TeleMental Health Therapy Services

TeleMental health offers several advantages such as convenience and flexibility. It is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption of service (e.g. phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see various details such as facial expressions. Or, if audio quality is lacking for some reason, I might not hear differences in your tone of voice I could easily pick up if you were in my office.

Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. As the therapist, I will take every precaution to ensure a technologically secure and environmentally private psychotherapy session. As the client, you are responsible for finding a private quiet location where the session will be conducted. Consider using a "do not disturb" sign/note on the door. The virtual session must be conducted on a Wi-Fi connection or other high speed internet connection for the best connection and to minimize disruption.



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In Case of Technology Failure

I understand that during a TeleMental health session we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technological complications and the session cannot be completed via online video conferencing, please call Christy at **940-294-7115** or Dr. Pam **940-294-7124**. Please make sure you have a phone accessible and that I have your phone number. We may also reschedule if there are problems with connectivity.

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, passwords, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear our conversation. **PLEASE INITIAL HERE** _____

Recording of Sessions

I understand that there will be no recording of any sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law. **PLEASE INITIAL HERE** _____

Emergency Management Plan

Acorn is not emergency provider. Please call the MHMR Crisis Team at 1-800-762-0157 or go to the closest ER. Once the crisis is being handled, please contact me with information about what has occurred. I care and I want to integrate that information into our treatment plan. I also am not available after hours at times and want you to have the highest quality of care. As a precaution, please identify two (2) nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. These all must be completed to participate in TeleMental health services.

Hospital Name and Location: _____

Hospital Telephone Number _____

Emergency Contact Person _____

Relationship _____ Telephone Number _____

You may alternatively follow this plan:

Call Crisis Hotline **1-800-762-0157**

Call **911**

Go to the **emergency room** of your choice



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Treatment Philosophy

This practice focuses on women, children, and families. With adults, we use experiential and trauma informed treatments that include homework. With children and families, a combination of art, play and trauma informed treatments will be utilized to assist in each member of the family communicating their viewpoint to the other. Parents will be taught skills and given advice, but they are responsible for informing me accurately about the environment and their goals for treatment. With all clients, the adults will communicate their goals to me, and I 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. Therapy may include the release of intense emotions, memory recall of negative events and changes in the family. These can be difficult to navigate at times. A client may regress during treatment. Please inform me of these issues so they can be a part of the treatment. Progress can also appear to be a simple growth curve. Please talk with me if you have any questions or notice any concerns.

_____ Christian Evidence Based

_____ Evidence Based

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 sees 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. **PLEASE INITIAL HERE** _____

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. **PLEASE INITIAL HERE** _____

Social Media Policy

Acorn manages and maintains several public media profiles: Facebook, LinkedIn, Twitter and Pinterest to name a few. This is the primary way we educate our community about mental health and parenting, as well as offer classes both educational and therapeutic. Please connect to these accounts for information about upcoming events. **PLEASE INITIAL HERE** _____

However, these accounts are not private mediums. Please contact Acorn through our client portal to speak about treatment issues. If you have any questions about our social media policy, please ask me. **PLEASE INITIAL HERE** _____

Appointments

Most appointments are 45-50 minutes in length. The initial session focuses on history, answering questions, and preliminary treatment planning. In treating children or families, this session is reserved for the primary caregivers only, preferably both parents. **PLEASE INITIAL HERE** _____

In high conflict custody or divorce cases, all coparents are encouraged to have contact with the therapist-both at intake and in an ongoing manner. Online 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 cancellation fees [full fee], which are automatically processed through the billing system. **PLEASE INITIAL HERE** _____

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



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If you have an emergency, please call the Denton County Crisis 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 4-6 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** _____

Contact Policy

Our therapeutic work occurs during our appointments. If you choose to send a nonscheduling message between sessions, we will address those concerns in session. If the contact-message or phone call- takes more than 15 minutes per session a fee may be charged. **PLEASE INITIAL HERE** _____

Please do not text us. **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 conference. These will incur fees based on \$40 per 15 minutes. **PLEASE INITIAL HERE** _____

If a clinician or records are subpoenaed for court, Acorn requires written release of information and a signed copy of our Advisement for Court Involvement. **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. I consider you to no longer be a client if 1 month has passed since our last session/contact. **PLEASE INITIAL HERE** _____

If at some point, I 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** _____



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Professional Fees | GFE

Acorn provides superbills and flex spending statements but does not bill insurance or submit electronic bills. FSA and Superbills are **not** available for court ordered treatment such as Reunification Counseling or Parent Facilitation.

Individual/Family/ Consultations 45-50 minute sessions, 90834, 90847, 90846	\$140 Play therapy for 12 and under: \$150
Individual/Family/ Consultation 55-60 minute sessions, 90837	\$150
Court Ordered/Court Involved Counseling	\$160
Group	\$30 per session per person
Screening	\$25 per client, covers up to 5 persons reporting
Professional Supervision	\$100 per session [Registered Play Therapy] \$75 [Professional Counselor only]
Cancellation Fee	Full Fee
Retainer for Parent Facilitation and Reunification Counseling	\$2000.00 (\$1000 per coparent)
Email/Reports/Phone**	\$160 per hour or \$40 per 15 min. Emails are expected to take 15 min to read, write and respond.
Court	Retainer of \$2000 covers 1 business day in court
Copies	\$1 per page printed, free if electronically accepted
Notarized Documents	\$25

**These services will be prorated every 15 minutes.

Financially Responsible Party: _____ Date: _____

Acorn estimates that each individual counseling client will spend at least 6 weekly sessions to develop a good treatment relationship, understanding of how the client responds to treatment, and develop a good treatment plan. After that, the sessions will be dependent on multiple factors that are hard to predict. Many of our clients have a reduction in symptoms within 6 weeks and will complete treatment within 3-6 months. However, some clients stay for up to 2 years depending on their needs. I will work with you to be transparent about these issues. Certain types of cases such as Reunification Counseling and Parent Facilitation incur more costs due to the need to read and write reports, coordinate with attorneys, review OFW, and write more emails. This is especially true in the beginning of these cases.

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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 is required to release records to others. You also have the 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 BHEC. 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

Any complaints or grievances from the client regarding the performance or actions of a therapist shall follow this procedure:

1. Person having a complaint or grievance regarding the Therapist must discuss the matter with the Therapist in person before pursuing it in any other manner.
2. If, after discussion, the client decides to pursue a complaint, he/she must then submit a written letter detailing the complaint or grievance to the Therapist. The Therapist will, within 30 days, provide a written response to the grievance to client. Both letters will be forwarded to Christy Graham, the president of Acorn Counseling Education Services.
3. If appropriate, the Therapist will then meet with the client and their attorneys (if any) to discuss the matter.

PLEASE INITIAL HERE _____

The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint.

Texas Behavioral Health Executive Council

333 Guadalupe St., Ste. 3-900 Austin, Texas 78701 Tel. (512) 305-7700 1-800-821-3205 24-hour, toll-free complaint system

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 a 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 therapist's 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:

1. 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.
2. 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.
3. 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. Acorn prefers to submit information to the court as Treatment Updates or Summaries and not provide session notes. Please craft requests accordingly.
4. 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 me to use and disclose your health information for these purposes.
5. 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 revealed. If a referral is needed, information will be shared to assist in coordination or continuity of services.
6. 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.



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- 7. 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.
- 8. Confidentiality in groups is limited by their nature.
- 9. 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. Any other communication, aside from face to face interactions, implies authorization. I authorize email/phone communication between ourselves and the therapist/office by communicating via email/cell phone and by providing our email address/cell phone number to the therapist. I will NOT TEXT Acorn. 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
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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
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Parent or Guardian	Date
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