**Harvest Moon Counseling, LLC**
**Natalie Cinotto, M.A., M.A., LPC-A**
**Supervised by Dr. Timothy Brown, LPC-S**

HARVEST MOON

natalie@harvestmooncounseling.com
832-707-1816

# Intake Form and Consent & Personal Data Record

Name: ____________________________________ Date:_____________

Parent(s)/Guardian(s) Names (if client is a minor)

____________________________________________ Is there a divorce decree? No ( ) Yes ( )

Date of Birth:_________________________________ Gender: ______________ Pronouns: ______________

Address:_____________________________________ City/State/Zip: ________________________________

Home Phone: _________________________________ Cell Phone:___________________________________

Emergency contact person's name, address, and phone number:

____________________________________________________________________________________

____________________________________________________________________________________

Marital Status: Never Married Domestic Partnership Married Separated Divorced Widowed

Phone Number:__________________________

Employer/School:______________________________

How did you hear about Harvest Moon Counseling?: ______________________

**Expectations/Goals for counseling**

The number of sessions for each individual/family will depend upon the unique circumstances of the individual/family. Some individuals/families may require only a few sessions in order to reach their goals and expectations; while others may take several months or more. Each client is in control of their counseling, with the exception of a minor, and can discontinue services. In the case of a minor, the parent/legal guardian has the right to discontinue counseling at any time. However, if you feel you or your child are ready to terminate counseling, please allow at least one session to discuss your decision and to have closure.

**Please describe the following**:

What currently brings you to counseling?

_______________________________________________________________________________________

_______________________________________________________________________________________

Please describe what you hope to gain from your/your child's/families counseling experience.

_______________________________________________________________________________________

_______________________________________________________________________________________

**Are you presently under the care of a psychiatrist?** ( ) **No** ( ) **Yes** If yes, please complete the following:

Name of Psychiatrist: ______________________________ Phone ________________

**Have you ever been under the care of a counselor?** ( ) **No** ( ) **Yes** If yes, please complete the following:

**Was it a positive experience?** ( ) **No** ( ) **Yes**

What did you like/not like about your therapeutic experience?

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Year? ____________

List any past diagnoses: ______________________________________________________________

List Current Diagnoses: ______________________________________________________________

**Current Psychiatric Medications**

| *Name of Medication* | *Dosage* | *How long have you taken this medicine?* | *Prescribed for?* | *Response to medication. (Side Effects, helpfulness, etc)* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Clients Medical issues**: (examples: diabetes, seizures, cancer, blood pressure, headaches, surgeries, allergies)

______________________________________________________________________________

______________________________________________________________________________

**Family Medical History**: (examples: diabetes, cancer, blood pressure, headaches, surgeries, allergies.) etc:

______________________________________________________________________________

______________________________________________________________________________

**Family psychiatric history**: please include any mental health diagnosis given to immediate family members:

______________________________________________________________________________

______________________________________________________________________________

**How would you rate your current physical health?**

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

______________________________________________________________________________

**How would you rate your current sleeping habits?**

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

______________________________________________________________________________

**Please list any difficulties you experience with your appetite or eating problems:**

____________________________________________________________________________

**Are you currently experiencing overwhelming sadness, grief or depression? Yes No**

If yes, for approximately how long?____________________________________________

**Are you currently experiencing anxiety, panics attacks or have any phobias? Yes No**

If yes, when did you begin experiencing this? _______________________________________

**Are you currently experiencing any chronic pain? Yes No**

If yes, please describe: _____________________________________________________

**Do you drink alcohol more than once a week? Yes No**

**How often do you engage in recreational drug use?**

Daily Weekly Monthly Infrequently Never

**Are you currently in a romantic relationship? Yes No**

If yes, for how long? ______________________________________________________

**What significant life changes or stressful events have you experienced recently?**

____________________________________________________________________________

____________________________________________________________________________

**Presenting Problems (Check all that apply):**

___ Adjustment Issues
___ Unstable mood
___ Depression
___ Grief/loss
___ Suicidal behavior
___ Suicidal thoughts

___ Substance abuse
___ Stress
___ Relationship issues
___ Physical Abuse
___ Emotional Abuse
___ Sexual Abuse
___ Parenting concerns
___ Trauma

___ Psychosis
___ Neglect, abandonment
___ Sexual dysfunction
___ School/Work difficulties
___ Gender identity problems
___ Anxiety
___ Anger

**Symptoms (Check all that apply):**

___ Change in appetite
___ Change in sleep patterns
___ Racing thoughts
___ Prolonged Sadness
___ Panic attacks
___ Low self-esteem
___ Anger outbursts
___ Lack of motivation
___ Poor impulse control
___ Increased energy level
___ Physical aggression
___ Social isolation

____ Destruction of property
___ Excessive worry
___ Self-harm behavior
___ Excessive guilt
___ Erratic behavior
___ Crying spells
___ Obsessive thoughts
___ Difficulty concentrating
___ Compulsive behavior
___ Weight loss/gain
___ Paranoid thoughts
____ Delusions

____ Lack of hygiene
___ Visual Hallucinations
___ Auditory Hallucinations
___ Decline in school performance
___ Decline in work performance
___ Alcohol dependence
___ Drug dependence
___ Flat emotions
___ Impaired memory

**Psychological Services:** Throughout our time together we will be targeting and working towards your goal(s) for therapy. Psychotherapy calls for an active effort on your part as well. I will work with you in facilitating movement towards your goals, however, in order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. During this process there are both possible benefits and risks that may occur. During sessions it is possible that you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. In the case of couples and family therapy, family members or partners may experience these types of feelings together. Therapy has also been shown to have many possible benefits leading to improved relationships, increased ability to deal effectively with stress, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience, and it is important that we discuss any questions, discomfort, or concerns you have regarding the psychotherapy process. I will consistently assess your treatment goals and progress with you. If your situation fails to improve or deteriorates, I will discuss with you changes that may be necessary for the sessions and/or provide referrals to another professional.

**Confidentiality:** The law protects the privacy of communications between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form. While I will maintain confidentiality with my clients, there are some instances in which I am obligated by law and/or professional ethics to report to the correct authorities. These include**:**

**Child Abuse/Neglect:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

**Abuse/Neglect of the Elderly and Disabled:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.

**Sexual Misconduct by a Therapist:** I am required to report any incidents of sexual misconduct by a current or former therapist to the offending therapist’s licensing authority.

**Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case. If a complaint is filed against myself with a regulatory authority, I hold the right to subpoena confidential mental health information relevant to that complaint.
**Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
**Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

I may seek out consultation with other mental health professionals or my direct supervisor, Dr. Brown, about your case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important for our work together. I will note all consultations in your Clinical Record.
I also have contracts with some business services, such as a billing service, electronic claims processing service, and email services. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. A copy of these agreements will be made available for your inspection on request.
In the case of family or couple sessions all notes of sessions are kept in a combined file and will require all adult participants' authorization to release information contained in this file. Occasionally only some members of the family (or perhaps only one) are present for a session. It is my policy to keep information confidential outside the family, however, to share information between family members where that seems both practical and likely to be helpful, in my professional judgment. If you have any questions about this policy, please discuss this with me. In the event that a breach of data occurs I will contact any clients that I believe have been affected and notify them of the information that may have been reached.
**Minors and Parents:** Clients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records at any time. However, I ask that you as a parent to be aware that privacy in therapy is often crucial to successful progress. Although I will provide records as the law requires if requested, I ask that parents participate in a session first so that we can have an open dialogue with all parties involved rather than have the minor feel that their privacy was violated and possibly hinder their progress in therapy. I will provide the parents with general information about the progress of treatment and attendance. In the case of a child custody

order, I will require a copy of the most recent custody order decree indicating parental rights or guardianship for my records before initiating treatment.

**Payment for Service:** My rate for a standard 50-minute session is $120 for individuals and $150 for couples/family. I am not operating within any insurance networks, however, I can provide you with a "super bill", a document that you can send to your insurance company to request out-of-network reimbursement. You (not your insurance company) are responsible for full payment of fees. I recommend that you contact your insurance company in advance of your appointment to verify your benefits coverage.

Finances should *not* prevent you from receiving services! If my regular rates would hinder you from obtaining therapy, please bring this to my attention so that we can find the best fit for you. I request that clients pay fees or charges at the end of each session unless other arrangements have been made in advance. I accept most credit/debit cards, checks, and cash.

**Cancellations and No Shows** I will charge a $50.00 fee for failure to be present at scheduled appointments. In order to cancel an appointment you must call 24 hours in advance to allow time for me to fill that appointment time. Failure to give 24 hour notice on a cancelled appointment will still incur a $50 charge.

**Legal Service:** I do not provide legal testimony services. If compelled to provide those legal testimony services, there are additional fees which are substantially higher than my fees for clinical services. My fee is $300 per hour with a minimum of 5 billable hours payable in advance.

**Emergencies:** If there is an emergency, please call 911, contact local authorities, or direct yourself to the nearest hospital. I am not always available, and you will get the best possible care in those instances at a hospital. If a non-emergency incident has come up during the week that cannot wait until your next appointment, you may give me a call so that we can set another session. If I am not immediately available, I will return your call as quickly as possible. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**Appointments and Contact:** When you make an appointment, that time is reserved for you. Please make every effort to be on time for scheduled appointments. If you must cancel an appointment or will be more than a few minutes late, please provide as much notice as you can. I try my best to respond within 24 hours of contact. Please keep in mind that in order to protect your confidentiality phone messages and emails should be kept to scheduling matters only.

**Social Media:** I do not communicate with any of my clients through social media. I do not accept Friend or Contact requests from current or former clients on social media. If I discover that I have accidentally established an online relationship with you, I will cancel that relationship. I believe that including clients as social networking contacts may not only compromise client confidentiality and our respective privacy, but also blur the boundaries of our professional relationship.

**Therapeutic Relationship:** The process of counseling involves a unique relationship between the counselor and client. It is common for a counselor and a client to form a special bond. Because of this close relationship, it may feel natural to want to invite me to social events, give me gifts, or ask me to write a letter of recommendation. However, the nature of our relationship is counselor-client, not social. To follow best practice and protect your confidentiality, we must limit our interactions to the counseling sessions and professional communication.

## HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONS ABOUT YOU MAY BE USED AND DISCLOSED AND HOU YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how I may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

### Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, my company, and others outside of my office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other used required by law.

**Treatment:** I will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, I would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining authorization for treatment may require that your relevant protected health information be disclosed to the health plan.

**Healthcare Operations**: I may use or disclosed, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of Licensed Professional Counselor Interns, and licensing. For example, I may call you by a name in the waiting room when your provider is ready to see you. I may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. I may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates. Under the law, I must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your authorization or opportunity to object unless required by lay.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS:**

You have the right to inspect and receive a copy of your protected health information. My practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative. Action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on the disclosure of your protected health information. This means you may ask me not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from me by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from me. You have the right to have your physician amend you protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with me and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

**Questions and Complaints**- If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 832-707-1816. If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to me at natalie@harvestmooncounseling.com.

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.

Owner of Harvest Moon Counseling, LLC
Natalie Cinotto
License Professional Counselor- Associate
License #86778

Supervisor
Timothy Brown Jr.
License Professional Counselor
License #71701

**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
https://www.bhec.texas.gov/discipline-and-complaints/index.html Initials______

## ACKNOWLEDGEMENT/CONSENT TO SERVICES

I understand and accept Harvest Moon Counseling, LLC policies and practices. This practice is hereby granted consent to contact me as specified above, and for the use and disclosure of my health information as described in those policies for therapy, treatment, diagnostic assessments, case coordination, consultation, payment, health care operations and other treatment/services recommended and considered necessary by Harvest Moon Counseling, LLC. I hereby consent to evaluation and treatment for myself and/or my dependent(s) specified on the Personal Data Record.

I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist.

I am aware that I may stop my treatment with my therapist at any time. Harvest Moon Counseling, LLC will provide referrals for me to continue treatment with other professionals at my discretion. The only thing I will still be responsible for is paying for the services I have already received.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive at this clinic. I understand that if payments for the services I receive are not rendered, then the counselor may stop my treatment.

I have been informed that any information regarding services at Harvest Moon Counseling, LLC are subject to release only by my informed and written consent or by exceptions listed above. I have also been informed that patient identifying information about me may be exchanged between office staff and other designated/contracted providers for continuity of care purposes.

I authorize this clinic to release any medical information necessary to process claims for the services provided. I authorize payment of governmental/medical benefits to this clinic for services provided. I understand that I remain responsible for any and all charges.

______________________________________________ ____________
Client or Authorized Representative Signature Date

______________________________________________
Printed Name

______________________________________________
Therapist Signature