Records and Confidentiality: All of our communications become part of the clinical record. Records are the property of New Outlook Counseling. Adult client records are disposed of six years after the file is closed. Minor client records are disposed of six years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) you are a danger to yourself or someone else; b) you disclose sexual contact with another mental health professional; c) I am ordered by a court to disclose information; d) you direct me to release your records; e) there is a reason to believe that abuse or neglect of a child, elderly, or disabled person occurred or a situation exists possibly leading to abuse or neglect; or f) I am otherwise required by law to disclose information.

Should you or an entity through your signature request a copy of you or your child's counseling records please be aware that a $30.00 record preparation fee will be incurred and a "Release of Records" form must be signed. An overall counseling summary in lieu of records may also be provided. A fee of $30.00 per 15 minutes is charged for preparation time. If records are subpoenaed this does not indicate an automatic release of records and is at liberty to be squashed should it be deemed not in the client's best interest. To further protect your confidentiality if I see you in public I will only acknowledge you if you approach me first.

Court: It is in your best interest to know that conducting expert witness/testimonial service is not in my area of interest or expertise. I do not agree to serve as an expert witness or to provide testimonial services for you, and you agree not to cause my services to be used in this way. If you are seeking counseling for court or court related purposes or motivations I will provide you alternative appropriate sources. Should you, your attorney, your spouse or ex-spouses attorney subpoena me or your client files as a factual case witness or involve me in court related proceedings, you agree to pay $100.00 for every hour of my time involved, including case preparation, travel, witness time, and any wait time related to a court related process. You further agree to pay a retainer fee of $800.00 at the time a subpoena is served to be applied toward these charges. If a subpoena is issued for me it will be turned over to an attorney, and I will consult with an attorney as necessary at your expense. A bill will be rendered to you for immediate payment when a subpoena is issued. If you have a suspicion that your case will be going to court, or you will need therapist testimony, please let me know before a counseling relationship is established, and appropriate referral sources will be provided to you.

Please note* 24 hour advance notice is required if a cancellation occurs related to a court process, including dismissal of case. If a 24 hour notification is not made, a fee of $800.00 will be billed. (8hrs @ $100.00 per hour)

Alaina Mount, MS, LPC 9535 Forest Lane Suite 288, Dallas, TX 75243

CONFIDENTIALITY & CONSENT FOR SERVICES

This agency 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. Specific information pertaining to your case will not be released to anyone except for specific billing purposes, your request for a release, situations involving risk to harm (see below), 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 ethical code. Please be aware of the following exceptions to privileged communications:

1. Any evidence or reason to believe that a situation of child, elderly or handicap abuse and/or neglect exists. By law, this information must be reported to the Texas Department of Protective and Regulatory Services.

2. Any probability of physical harm to yourself or others. Protection from physical injury takes precedence over confidentiality and the therapist's primary responsibility is his/her "duty to warn" if she/he believes someone to be in imminent physical danger. Therefore, if an individual intends to take harmful, dangerous, or criminal action against self or another, 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.

4. If a third-party billable service is paying or reimbursing for counseling services it may be necessary to provide the billable party with counseling diagnoses, nature, and progress.

5. If client discloses that they have a disease commonly known to be both communicable and life threatening counselors may be justified in disclosing information to identifiable third parties if they are known to be at demonstrable and high risk of contracting the disease.

I (we) do hereby give my (our) consent for counseling and/or related services at this facility. I (we) understand that all information pertaining to my (our) services all remain completely confidential except in those cases where confidentiality is limited. These limits of confidentiality, as prescribed by Texas law, have been explained to me. I (we) further understand that any release of information concerning my (our) services shall occur only with my (our) written consent, excluding that above stipulated exceptions.

_____ _____

Client/Guardian Signature Date

_____ _____

Counselor Signature Date

Alaina Mount, MS, LPC 9535 Forest Lane Suite 288, Dallas, TX 75243

Court Testimony Agreement

☐ I am seeking counseling for court testimony or court involvement on behalf of Alaina Mount, MS, LPC myself, my child, or a family member.

☐ I am NOT seeking counseling for court testimony or court involvement on behalf of Alaina Mount, MS, LPC for myself, my child, or a family member.

Court: It is in your best interest to know that conducting expert witness/testimonial service is not in my area of interest or expertise. I do not agree to serve as an expert witness or to provide testimonial services for you, your child or any member of your family, and you agree not to cause my services to be used in this way. If you are seeking counseling for court of court-related purposes or motivations, I will provide you with alternative appropriate referral sources. Should you, your attorney, your spouse or ex-spouses attorney subpoena me or your client file as a factual case witness, or involve me in court-related proceedings, you agree to pay $100.00 for every hour of my time involved, including case preparation, travel, witness time, and any wait time related to a court related process. You further agree to pay a retainer fee of $800.00 at the time a subpoena is served to be applied toward these charges. If a subpoena is issued for me it will be turned over to an attorney, and I will consult with an attorney as necessary at your expense. A bill will be rendered to you for immediate payment when a subpoena is issued. If you have a suspicion that your case will be going to court, or you will need therapist testimony, please let me know before a counseling relationship is established, and appropriate referral sources will be provided to you.

Please note* 24 hour advance notice is required if a cancellation occurs related to a court process, including dismissal of case. If a 24 hour notification is not made, a fee of $800.00 will be billed. (8hrs @ $100.00 per hour)

By your signature below, you are indicating that you read and understood this document, that you are in full agreement with the contents of this document, and that any questions you had about this document were answered to your satisfaction.

Client/Guardian Signature _____ Date _____

Counselor Signature _____ Date _____

CONSENT FOR DISCLOSURE OF INFORMATION

I, _____hereby provide authorization for Alaina Mount, MS, LPC

To obtain and/or provide the following information:

_____

_____

To/From the following parties/agencies:

_____ *Agency Name*	New Outlook Counseling
_____ *Contact Name*	Alaina Mount, MS, LPC
_____ *Address*	9535 Forest Lane, Suite 258
_____ *City, State, Zip Code*	Dallas, TX 75243
	Fax Number: 214-504-1337

_____ _____

Client/Guardian Signature Date

_____ _____

Counselor Signature Date

Alaina Mount, MS, LPC 9535 Forest Lane Suite 288, Dallas,
TX 75243

HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment payment or health care operations (TPO) and for other purposes health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health insurance may be used and disclosed by your therapist, our office staff and others outside of our 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 therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure 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 approval for a hospital stay or higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose as needed, your protected health information to support the business activities of your therapists practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing, and fund raising activities, conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students and Licensed Professional Counselor Interns who see clients at our office. In addition, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other permitted and required uses and disclosures will be made only with your consent, authorization and opportunity to object, unless required by law. You may revoke this authorization in writing at any time, except to the extent that your therapist or therapists practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgment of Receipt of HIPPA Notice of Privacy Practices for this office:

_____ _____

Client Signature (parent/guardian of minor patient) Date

Consent for use and disclosure of health information:

I hereby permit and release Alaina Mount, MS, LPC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's, PPO's, managed care organizations, IPA's or other governmental or third party payers, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client Signature (parent/guardian of minor patient) Date

You have the right to request restriction of uses on disclosure of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Alaina Mount, MS, LPC 9535 Forest Lane Suite 288, Dallas,
TX 75243

General Intake Information

Name: _____Date: _____

Date of Birth: _____ Age: _____Gender: M F

Home Address: _____
City St Zip

Home Phone #:_____ Cell Phone #: _____ Work Phone #: _____

Contact you at work? Yes No Contact you at home? Yes No Contact you on cell? Yes No Email Address: _____ May I correspond with you via email at the address specified above? Yes No

Occupation: _____Length of time at this job: _____

Work days & hours: _____Would you consider this job stressful? Yes No

Referred by: _____

Activities and/or hobbies you enjoy: _____

History of learning, emotional, or behavioral problems? Yes No

(*if yes explain*) _____

History of alcohol, drug/substance abuse? Yes No

(*if yes explain*) _____

History of criminal activity? Yes No

(*if yes explain*) _____

Emergency Contact Name: _____

Relationship to you: _____Phone Number: _____

Your signature on page 5 indicates consent to contact this person in the rare case an emergency should occur.

General Health: Excellent Good Fair Poor Date of last physical: _____

Primary Care Physician: _____Phone Number: _____

Address: _____
City St Zip

Current Diagnosis or Medical Concerns: _____

Psychiatrist: _____Phone Number: _____

Address: _____
City St Zip

Current Diagnosis or Medical Concerns: _____

List all current medications you are taking:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Have you ever seen a mental health professional? Yes No *Counselor, Psychologist, Psychiatrist*

*Are you currently in counseling elsewhere? Yes No

If yes we require written confirmation of the counselor's consent for treatment at New Outlook Counseling.

Past Counseling History:

Date	Date of Service	Agency and Therapist Services
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for mental health concerns? Yes No Date: _____

Briefly describe why you are seeking counseling?

_____

_____

_____

_____

Present Household: (*Anyone currently living with you*)

Name	Age	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Marital Status: Indicate all that apply and duration of each. (Example, 1980 – 2001)

Married _____Separated _____ Divorced_____ Widowed _____

Married _____Separated _____ Divorced_____ Widowed _____

Married _____Separated _____ Divorced_____ Widowed _____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly

1 ---------- 2 ----------3----------4 ----------5

Are you currently involved in a custody dispute? Yes No

Family of Origin:

Name	Age	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family of Origin Atmosphere:

Describe your relationship with your parents as a young child:

_____

_____

Please give three adjectives to describe your relationship with your mother as a young child:

_____ _____ _____

Please give three adjectives to describe your relationship with your father as a young child:

_____ _____ _____

Which parent do you feel closest to, and why?

_____

_____

When you were upset as a child, what did you do?

_____

_____

In general, how do you think your overall experiences with your parents have affected your adult personality?

_____

_____

Please summarize your current relationship with your parents.

_____

_____

Please summarize your religious/spiritual beliefs and the importance they play in your life.

_____

_____

Please summarize any major life changing events you have experienced which have positively or negatively affected you.

_____

_____

Current Trauma/Stressors (Check all that apply)

_____ Divorce/Separation

_____ Relationship Difficulties

_____ Victim of trauma

_____ Family Stressors

_____ Other (please explain)

_____Death of a significant person

_____Incarcerated family member

_____Health Problems

_____Work related problems

_____

_____

Interpersonal Problems (Check all that apply)

____Aggressive behavior

____Alcohol or drug abuse

____Other (please explain)

____Temper Outbursts

____ Sexual Acting-Out

____Boundary Issues

_____Social Anxiety

_____

_____

Current struggles in our life that you would like to address in counseling. (Check all that apply)

Issues Related To Abuse

_____ Current or past physical abuse

Career/Academic Issues

_____Colleague/Cohort problems

_____ Current or past sexual abuse

_____ Current or past emotional abuse

_____ Current or past neglect

_____ History of abandonment/rejection

_____ History of family domestic violence

Mood Related Concerns

_____ Disturbing Memories

_____ Sadness/Depression

_____ Suicidal Thoughts

_____ Feelings of guilt/shame

_____ Excessive Worrying

_____ Estranged Relationships

Behavioral Concerns

_____ Aggression toward others

_____ Drug/alcohol use

_____ Hyperactive/Impulsivity

_____ Betraying relationships

_____ Cutting

_____ Engaging in high-risk behaviors

_____Work performance

_____Failing grades

_____Career dissatisfaction

Family Relationship Concerns

_____Adjusting to family changes

_____Parenting/Discipline concerns

_____Parent/Child Relationship

_____Divorce

_____Separation

Other Concerns

_____Sexual identity questioning

_____Appetite eating concerns

_____Sleep problems

_____Stress management

_____ADHD/ADD management

_____Loneliness

Other struggles you would like to address: Place a * by the most significant issues

_____

_____

Please summarize your current goals for counseling.

_____

_____

_____ _____

Client/Guardian Signature Date