**Move Forward Counseling LLC**

825 Eden Road
Lancaster PA 17601-4713
717-462-7003

### 1. Instructions for Completing Intake Paperwork

## Please Read Before Completing the Intake Paperwork

This paperwork must be completed no later than a day before your intake appointment. If the paperwork is not completed in time, then the therapist may need to cancel your appointment. Please take time to fully answer the questions the best you can and submit the paperwork in a timely manner.

## 2. Notice of Privacy Practices

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.

• Give you this notice of my legal duties and privacy practices with respect to health information.

• Follow the terms of the notice that is currently in effect.

• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Client Signature (required if Client is age 14+):

Parent/Guardian Signature (If a this does not apply to you, please put N/A in the box provided):

## 3. Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

Your Therapist

For more information about your therapist's education and licensing information, please see our website at www.moveforwardpa.com or speak to your therapist directly.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

While I hope that your experience in therapy is all progress, unexpected events or life circumstances could lead to worsening of your condition. I will be honest with you if I have assessed that you need additional treatment or a higher level of care and I will help you get the help that you need. If a higher level of care is recommended I will not continue to treat you at an outpatient level of care because I care about you and want you to get the help you need.

Confidentiality

The session content and all relevant materials to the client’s treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. Suspected neglect of the parties named in items #3 and # 4.

6. If a court of law issues a legitimate court order for information stated on the court order.

7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert’s report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you

acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

I may only be able to respond to voice messages or messages through the portal during my working hours. So please be aware that if there is an emergency outside of my regular hours, you should call 911 or your local crisis center.

I do not communicate with or become "friends, contacts or followers" on any social media platform with clients that I work with, even after your therapy has ended. If you need to be in contact with me, please do so via phone during my regular working hours.

## Teletherapy Consent

For clients who choose to use teletherapy services: I understand that teletherapy is 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 Move Forward Counseling LLC to provide health care services to me via teletherapy.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to teletherapy. As always, if you choose to use your health insurance, your carrier will have access to your medical records for quality review/audit. I understand that I will be responsible for any copayments or coinsurances that apply to my teletherapy visit. I also understand that my insurance company may not have teletherapy benefits and therefore if I elect to use these services I will have to “self-pay” for them.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Move Forward Counseling LLC at info@moveforwardpa.com. As long as this consent is in force (has not been revoked) Move Forward Counseling LLC may provide health care services to me via teletherapy without the need for me to sign another consent form.

## Minors and Consent for Treatment

If the client is under 14 years of age consent of a parent/guardian is required for treatment.

Client Signature (required if Client is age 14+):

Parent or Guardian Signature (If a this does not apply to you, please put N/A in the box provided):

# 5. Coordination with your Primary Care Physician

## We encourage collaboration with your Primary Care Physician.

Please complete the below form if you would like us to communicate to your primary care doctor about your care.

- ☐ Please check this box if you DO NOT want any information released to your Primary Care Physician. If you have checked this box, you do not need to complete the rest of the form.

## Authorization to Use or Disclose Health Information

Client Name:

Client Date of Birth:

I authorize Move Forward Counseling, LLC to disclose and/or obtain my Protected Health Information (PHI) to/from my Primary Care Physician below:

Physician's Name:

Practice Name:

Physician Address:

Physician's Phone Number:

Physician's Fax Number:

Information that can be used or shared include (check appropriate boxes)

- ☐ Intake Evaluation/Summary
- ☐ Psychological/Psychiatric Evaluation
- ☐ Medical History/Medical Evaluation
- ☐ Drug/Alcohol Information/Evaluation
- ☐ Academic/Educational Information/Records
- ☐ Discharge Summary/Aftercare Instructions
- ☐ Referral/Treatment Summary
- ☐ Check here if you do not want drug/alcohol or HIV related information released

Other information that can be used or disclosed: Please Specify:

Information from the following dates can be used or released: If you authorize all dates, please write "all.":

This information is to be used for continuity of care and for the following purpose(s).

- [ ] Treatment Planning and Assessment
- [ ] Referral/Coordinating with Another Professional

Other (please fill in specifics)::

I understand that I am not obligated to authorize or disclose my Protected Health Information (PHI). I also understand that my refusal to authorize a disclosure of my Protected Health Information (PHI) will not affect my ability to receive treatment from Move Forward Counseling, LLC or my eligibility for benefits.

I understand that I may revoke or cancel this authorization at any time by notifying my therapist at Move Forward Counseling, LLC in writing, except to the extent that the agency has already acted upon it.

This authorization is valid for one year from the date below.

Date:

**8. Standard Intake Questionnaire**

## Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

## Current Symptoms

(check all that apply)

- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Crying Spells
- ☐ Depression
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Gender Dysphoria
- ☐ Guilt
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Irritability
- ☐ Libido Changes
- ☐ Loss of Interest
- ☐ Panic Attacks
- ☐ Racing Thoughts

- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Trauma History? Briefly describe only if you feel comfortable::

Have you experienced any of the following: fertility difficulties, miscarriage/still birth, abortion, difficulties in pregnancy/delivery, adoption, or the death of your child after birth?:

Have you personally experienced (or witnessed someone else) being treated in a disturbing manner due to racial, ethnic, or cultural factors?:

## Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Current and Previous medical conditions:

Previous surgeries:

If under age 18: Were there any difficulties with your birth or childhood development (such as walking, talking, toilet training, social skills or behavior)? If yes, please explain:

## Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grown up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

## Present Situation

Work:

What is your occupation?:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

How do you identify religiously or spiritually?:

Are there any legal issues you're dealing with currently or have experienced in the past?:

## Have you ever tried the following?

(check all that apply)

- ☐ Alcohol
- ☐ Tobacco (including vaping)
- ☐ Marijuana
- ☐ Hallucinogens (LSD, PCP)
- ☐ Heroin
- ☐ Methamphetamines
- ☐ Cocaine
- ☐ Stimulants (Pills)
- ☐ Ecstasy
- ☐ Methadone
- ☐ Bath Salts
- ☐ Spice
- ☐ Opiates

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

## Additional

List Your Strengths::

Anything else you want the therapist to know?:

## 10. Emergency Contact Release of Information

I give consent and authorize Move Forward Counseling, LLC to release information to the following person in the event of a medical or mental health emergency:

Emergency Contact Name:

Emergency Contact Address:

Emergency Contact Phone Number:

For the purpose of: care during a medical or mental health (suicidal/homicidal) emergency.

The information authorized to be released (please check below):

- ☐ Any information related to a medical concern or emergency.
- ☐ Any information needed to secure safety when suicidal or homicidal.
- ☐ Entire Title

I have been told that my records are confidential and information will not be shared except when required by law or when I have given my written permission. This release gives limited permission to contact the named person for the indicated purpose only. The release is effective until the time of discharge from services.

I understand that I may revoke or cancel this Authorization at any time, except to the extent that the agency has already acted upon it, by notification to Move Forward Counseling, LLC in writing.

I understand I am not required to sign this release in order to be treated at Move Forward Counseling, LLC. If I choose not to sign this release, I understand I am choosing instead for emergency professionals only to be called at 911 in the case of an emergency.

This authorization is valid for one year from the date below.

Date:

## 11. Release of Information (ROI)

Today's Date:

Client Name and Date of Birth:

I, the above named individual, authorize Move Forward Counseling, LLC to disclose and/or obtain my Protected Health Information (PHI) to/from the following person/entity

Name and/or Organization:

Address:

Phone Number:

Office Fax Number::

Office email address::

Information that can be used or shared include (check appropriate boxes)

- ☐ Attendance and Participation in Therapy
- ☐ Schedule / Re-Schedule or Cancel a therapy session
- ☐ Intake Evaluation/Summary
- ☐ Psychological/Psychiatric Evaluation
- ☐ Medical History/Medical Evaluation
- ☐ Drug/Alcohol Information/Evaluation
- ☐ Academic/Educational Information/Records
- ☐ Discharge Summary/Aftercare Instructions
- ☐ Referral or treatment summary
- ☐ Check here if you do not want drug/alcohol or HIV related information released.

Other information that can be used or disclosed: Please specify::

Information from the following dates can be used or released. If you authorize all dates, please write "all.":

This information is to be used for continuity of care and for the following purpose(s):

☐ Treatment Planning and Assessment

☐ Referral/Coordination with another Professional

Other (please be specific):

I understand that I am not obligated to authorize or disclose my Protected Health Information(PHI). I also understand that
my refusal to authorize a disclosure of my Protected Health Information(PHI) will not affect my ability to receive treatment
from Move Forward Counseling, LLC or my eligibility for benefits.
I understand that I may revoke or cancel this authorization
at anytime by notifying my therapist at Move Forward Counseling, LLC in writing, except to the extent that the agency has
already acted upon it.

Client Signature (required if Client is age 14+):

Parent/Guardian Signature (If this does not apply to you, please put N/A in the box provided):

This form will be valid for one year post discharge.

## 12. Requests for Therapist Completion of Forms

MFC therapists do not complete the following: Referrals for emotional support animals, FMLA paperwork, Disability or Requests for Accommodation forms, Recommendations related to custody, Worker's Compensation Forms, Other forms related to disability. Clients requesting such forms to be completed will be referred to their PCP or psychiatrist. MFC can provide, if requested and appropriate release signed, a letter indicating that the client is engaged in treatment with MFC.

Client Signature (required if Client is age 14+):

Parent/Guardian Signature (If this does not apply to you, please put N/A in the box provided):

## 0. Age Group 5- 11

Due to the children's age it is the therapist's expectation that during the initial appointment the parent be present. The parent may also need to be present at the first couple of sessions. The therapist will use this time to determine whether or not telehealth is the right fit for your children.:

# 0. Bridge Program Office Policies

Appointments:
The client (parent/legal guardian) and therapist mutually agree upon a scheduled appointment date and time. In the event or need to cancel or reschedule an appointment, please notify the therapist as soon as possible or at least 24 hours in advance of the appointment.

If the client shows up 10 minutes or more late for an appointment, the therapist reserves the right to cancel the appointment and the late fee will be charged.
If the client is thinking of discontinuing therapy, this should be discussed with the therapist.
If the client would like to return to therapy after being discharged, please contact us.

Emergencies:
The nature of private practice outpatient psychotherapy at times may mean that the therapist will not be easily available. In the event of a mental health or medical emergency please do not wait for the provider. The client (or parent/legal guardian) should contact Crisis Intervention at (717) 394-2631, call 911, or go to the nearest emergency room for care and treatment.

Social Media Policy:
We use various social media platforms to advertise our practice. In order to protect your confidentiality we will not interact with you in any way on Move Forward Counseling's social media pages. As a matter of ethics we also do not interact with clients in any manner if the therapist has a personal social media account. Thank you for helping us protect your confidentiality and maintain good therapist/client boundaries.

Litigation Limitation:
Due to the nature of the therapeutic process and that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, you agree that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor anyone else acting on your behalf will call on the therapist to testify in court or at any other proceeding. However, if an appearance at court on your behalf is required by law and you have signed a release form allowing this, the fee is $7,500 per day to reserve the therapist’s time and must be paid in full 30 days prior to the expected court date.

Infectious Diseases Policy:
Move Forward Counseling follows the recommendations of the Centers for Disease Control (CDC) in relationship to management of COVID and other infectious diseases. If you test positive for COVID or are experiencing any symptoms that could be a potentially contagious condition, we ask that you contact MFC staff prior to your in-office appointment and reschedule the appointment to be done via telehealth also If you have been exposed to a potentially contagious infection or disease, please notify your therapist before attending an in office appointment.

Client Signature (required if Client is age 14+):

Parent/Guardian Signature (If this does not apply to you, please put N/A in the box provided):