INTAKE FORM

Date: _____

CLIENT INFORMATION

Client Name:_____

Preferred pronouns: he/him she/her they/them _____

Name of parent/guardian (if under 18 years): _____

Client's date of birth _____/_____/_____ Age: _____

Address: _____
(street and number)

_____ _____ _____
(city) (state) (zip)

Client Cell phone _____ May I leave a message? Yes □ No □
May I text you? Yes □ No □

Parent/Guardian Cell phone _____ May I leave a message? Yes □ No □
May I text you? Yes □ No □

EMERGENCY CONTACT

Name: _____ Relationship to client: _____

Phone Number: _____ Alternative phone number: _____

Is there anyone you would like me to contact to discuss your situation?
No □ (You can move on to the next page)
Yes □ Please write their name and contact information below. Please sign the release of information giving me permission to contact them.

I, (client's name if over 18 or guardian's name) _____, give permission for Christy Montrone-Burns, LCSW, to contact the following person/agency to discuss my case:

Name/Agency:
Contact Information:

Name/Agency:
Contact Information:

Client or Guardian Signature: _____

Circles and Stones, LLC
Christy Montrone-Burns, LCSW, CNRC

INSURANCE & BILLING INFORMATION

(Please bring your insurance card to the first appointment. Thank you.)

Person responsible for payment: _____

Relationship to client: _____

Address: _____

Phone number: _____ ☐home ☐cell ☐work

Insurance Information:

Name of insured person: ☐(same as above) _____

Relationship to client: ☐(same as above)_____

Insured person's date of birth: _____ Employer:_____

Address: ☐(same as above)_____

Phone: ☐(same as above)_____ ☐home ☐cell ☐work

Insurance Provider Information: (Please bring your insurance card to the first appointment. Thank you.)

Name of provider: (Select Health, EMI, BlueCross, etc.)_____

Policy number: _____ Group number: _____

Phone: _____

What is your co-pay? _____

Alternative form of Payment (required information):

Credit Card/Debit/HSA #: _____ Exp. Date: _____ CVV_____

☐ I give permission to release my information to my insurance company for payment of services.

☐ I authorize the following credit card to be on file for Circles and Stones, LLC, and to charge it under the following circumstances: co-payment, services that are not covered by insurance, or a $60 charge for a missed or cancelled session within 24 hours of the appointment.

☐ I understand that I am responsible for understanding my mental health benefits through my insurance. Any claims that are denied will be paid with the credit or debit card on file.

Authorized signature: _____ Date: _____

Consent to Participate in the Mental Health Nutrition Therapy

Christy Montrone-Burns, LCSW, CRNC has been trained to:

- understand the relationship between specific nutrient deficiencies and mental health and behavior symptoms.
- assess the potential need for amino acid and nutrient support of neurotransmitter function in detoxing and recovering people with substance use disorders, other addictive behaviors, psychotropic drug-dependencies, depression, anxiety, insomnia, and other behavior disorders.
- design an individualized and targeted amino acid and supplemental protocol to address this potential need.
- identify common insufficiencies in diet, such as missing a meal or over-consumption of sugar, that may contribute to the above symptoms.
- give information about dietary changes which may address these insufficiencies and support their clients in making and maintaining these dietary and lifestyle changes.

This information can make your mental health therapy experience more productive. It integrates mental health philosophies such as Cognitive Behavior Therapy, DBT, Systems Theory, Solution Focused Therapy and is considered a trauma-informed approach. It may be used in conjunction with medication management, with certain limits, which are discussed in session.

STATEMENT OF UNDERSTANDING

I understand that Christy Montrone-Burns, LCSW, CRNC has been certified through the Academy for Addiction & Mental Health Nutrition as a Certified Recovery Nutrition Coach. I understand that she is not a medical doctor or a nurse, and does not by law diagnose or treat any medical conditions other than those mental health conditions she is licensed to diagnose and treat as a Licensed Clinical Social Worker, licensed in the state of Utah.

I further understand that it is my responsibility to discuss with my doctor, if I so wish, any recommendations or health concerns that Ms. Montrone-Burns mentions. Ms. Montrone-Burns' role is to help me to identify any lifestyle, dietary, or nutrient imbalances that may be contributing to my health issues, to suggest beneficial changes, and to support and encourage me in those changes.

I understand that nutritional supplements and food items may be offered to me during the therapy sessions. It is my choice if I decided to partake in the samples and will not hold Christy Montrone-Burns, LCSW responsible for any negative side effects, if they might occur.

I have been informed that the supplements recommended to me fall into the legal category of "Generally Regarded as Safe" (GRAS). This means that there should be no negative side effects nor should "my body need time to get used to them." However, I understand that any person may have an idiosyncratic reaction to any substance at any time. I therefore agree to stop any supplement which is causing me discomfort and to contact Ms. Montrone-Burns immediately. I agree to not hold her or Circles and Stones, LLC legally responsible for any negative reaction to a recommended supplement that I have used.

Date _____

Participant's Printed Name: _____

Participant's or Guardian's Signature: (if under age 18) _____

Guardian Printed Name: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how mental health information about you may be used and disclosed and how you can get access to this information.

Please review carefully

Our commitment to your privacy:

CIRCLES AND STONES, LLC AND CHRISTY MONTRONE-BURNS ARE REQUIRED TO PROVIDE THIS NOTICE TO YOU BY A NEW FEDERAL LAW, THE ***HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)***. THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION IN ACCORDANCE WITH THE ***HIPAA PRIVACY RULE***. PLEASE REVIEW IT CAREFULLY.

What we mean by your Protected Health Information (PHI)

Each time you visit us or any health care provider, information is collected about you regarding your physical and mental health. It may be information about your past, present or future health conditions; tests or treatment you received from us or from others; or information regarding payment for heal care. The data we collect from you is called the “PHI” which stands for “protected health information,” which goes into your medical records in our office.

How we use and disclose your protected health information with your consent:

We will use the information we collect to provide treatment to you, bill for services, and conduct health care operations.

Treatment refers to therapeutic services provided to you and may include coordinating or consulting with other health care professionals who are also providing services to you, such as your family physician or another mental health professional. Prior to consulting with another professional, we will obtain a signed Release of Information from you. At times, professional consultation may occur with other professionals to improve the quality of care to the client without disclosing any identifying information. In this case, a signed release of information will not be required and rules of confidentiality will be strictly adhered to.

Payment refers to collection of fees for services either from you, your insurance company, or any other third party. We may disclose your PHI to your health insurer to obtain reimbursement for your health care. It is your responsibility to confirm that therapy services are a covered benefit.

Health Care Operations refer to activities that are related to the performance and operation of this practice. This includes conducting required business duties, audits, and administrative services.

Disclosing your health information without your consent:

There are limited situations where we are required by law to share your information without your signed authorization.

These situations include:

1. A response to a serious threat to your health and safety, another person's health and safety, or to the general public. We share information only with persons who are able to help prevent or reduce the threat.
2. Any known or suspected abuse of a child, which includes physical abuse, sexual abuse, neglect, or exposure to domestic violence.
3. Lawsuits and other legal court proceedings or when otherwise required by law.
4. Providing access to workers' compensation or similar benefit programs.
5. Responding to inquiries or investigations by the Utah Division of Occupational and Professional Licensing in the event a complaint is filed against this therapy practice.

Mental Health Professionals Privacy Duties:

We are required by law to:

1. Maintain the privacy of your protected health information (PHI).
2. Provide this notice, which describes the way we may use and share your PHI.
3. Follow the terms of this notice currently in effect.

Client's Rights:

You have the right to:

1. Request restrictions on certain uses and disclosures of your PHI. However, we are not required to agree to a restriction you request.
2. Request and receive confidential communications of PHI by alternative means and at alternative location; for example, you may request that your statements be sent to an alternative address.
3. Inspect and/or receive a copy of your PHI. Under certain circumstances, we may deny your access to a portion of your PHI, and you may request a review of the denial.
4. Maintain a copy of this notice.
5. File a complaint if you believe your privacy rights have been violated. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you need more information or have questions about the privacy practices described above, please speak to your therapist. If you have a problem with how your PHI has been handled, or if you believe your privacy has been violated, as stated abuse, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. We will not in any way limit your care here or take any actions against you if you complain.

The effective date of this notice is August 11, 2019.

I acknowledge I have read the privacy practices of this agency.

_____ _____

Signature Date