Michael Malloy, L.C.S.W., A.C.S.W. **INTAKE FORM**

Private Practice, Counseling & Consultation: Individual, Marital and Group 615-376-6411

This *confidential information* is for use **only** by your counselor unless permitted by your signed release.

PERSONAL INFORMATION (spouse info is below) Today's Date_____

Name_____Phone ( )_____( )_____
home work

Address_____ _____
Street/Apt City State

Your Zipcode_ _ _ _ _-_ _ _ _ Is it appropriate to send your personal correspondence to this address? Yes / No

Your Birthday_____/_____/_____ your age_____ cell phone #_____

Your SSN _ _ _ - _ _ _ - _ _ _ email address_____ Private? Yes / No

Family Status: Single____ Married____, if so, date___/___/___ Separated____ Divorced____ Widowed____

Occupation_____Employer_____

How would you rate your physical health?

_____

Are you on any medications currently? _____if so, please list.

_____

_____

Name of your primary physician_____Address_____

_____ _____
City St ZIPCODE

Have you ever seen a counselor(s) or been hospitalized for mental health/emotional reasons?_____ if so, who/what facility or hospital:

_____ _____
Name Address City St ZIPCODE

_____ _____
Name Address City St ZIPCODE

Number of times?_____ Approximate date of last appointment?_____

Do you attend church/synagogue?_____ If so, where?_____
Church City

Your minister/pastor/priest's name:_____

Complete if applicable:

Spouse's Name_____Phone # ( )_____( )_____
cell work

_____
Address City State ZIPCODE

His/her date of Birth_____/_____/_____ age____ SSN _ _ _ - _ _ _ - _ _ _

His/her Occupation_____Employer_____

Children:

Name	Age	Living w/ you?	Yours & Spouses	Yours	Spouse's

REFERRAL INFORMATION

Who referred you?_____ _____
Name Phone

_____
Address City St Zipcode

General Functioning Complaints? (sleeplessness, low energy, etc.):_____

_____

Reason for seeking counseling:_____

_____

_____

What do you want to accomplish in counseling?_____

_____

_____

_____

Services provided:

Individual Therapy
Marriage and Family Therapy
Group Therapy centered around special needs such as codependency, stress management, addiction, abuse, etc.

Expectations from Therapy: Client's Responsibilities

People utilize therapy to help change what are often significant aspects of themselves (attitudes, behaviors, emotions, etc), their relationships (marriage or significant other relationships such as with parents, friends, children, other relatives, etc.) or other circumstances in life (employment, living environment, etc.) in order to reduce or alleviate problems and to lead a more fulfilling life. As a client, you will be expected to take an active role. As a professional, I can assist in effecting change, but cannot guarantee a specific outcome. You will determine the direction and be ultimately responsible for growth. If at any time you are dissatisfied with your therapy, please let me know in order that we can work together toward a solution.

Confidentiality

All information you reveal will be treated strictly confidential according to the attached HIPPA regulations. This means that the information will not be shared with anyone with the following three exceptions (1) when you have given written consent to share the information with a specific person or agency, (2) when it is deemed that you are at risk of hurting yourself or another person and (3) Tennessee law requires that child abuse in any form be reported to the Department of Human Services.

If you are referred by a physician or other health care professional, it is professional courtesy to maintain contact, as necessary, with that referral source. This may be done unless you request otherwise.

Parents or legal guardians will have access to pertinent information related to their minor children (under 16 years of age). Unless the courts have terminated parental rights, both parents have equal access to the records and information regarding minor children.

Referral

It is sometimes necessary to make a referral to another mental health professional to better accommodate your needs. If this is the case, every effort will be made to help you find an appropriate, affordable source of help. It may also be beneficial to make a referral to another source of help, such as a psychiatrist, lawyer, or self-help group. Your written permission would be obtained before any information could be released.

Credentials

I hold two graduate degrees and am licensed by the Tennessee Board of Healing Arts as a Clinical Social Worker (L.C.S.W.). I am also certified by the Academy of Certified Social Workers (A.C.S.W.) through the National Association of Social Workers.

Fee and Cancellation Policy

Your fee for 50 minutes of individual therapy will be $135 and $150 for marital/couple therapy. It is strongly suggested that marital work be done in two-hour sessions. **Twenty-four hour cancellation is required in order to avoid paying the fee for a missed session.** Voice mail is available 24 hours a day to receive your call. Should you be unable to contact me during a personal emergency, you may obtain assistance by calling the Crisis Line at 615-244-7444 or going to your local hospital emergency room.

OUR SERVICE AGREEMENT

1. Appointments must be canceled at least 24 hours prior to the appointment or the client will be billed for that session.

2. Any long distance calls accrued during the course of therapy will be charged to the client.

3. Phone calls lasting more than 10 minutes will be billed at the existing fee for the portion of time consumed by the call. Phone calls after the hour of 9:00 p.m. and before 7:00 a.m. will be billed at the rate of $150 per 50-minute time frame.

4. Out-of-office consultations---hospital visits, home visits, court appearances, or other types of consultations (which require the therapist to leave the office to provide counsel or consultation) can be provided to the client at a fee of $250 per session hour. Travel time to and from will be billed at this same rate.

5. On services covered by insurance, you, as the client are responsible for payment. You will be provided with a statement/receipt with all essential information. It is then your responsibility to seek reimbursement from the insurance company.

6. Expenses incurred in therapy are the responsibility of the person receiving the service (or your legal guardian).

7. Consultation with referral sources on the client's behalf will be billed at the existing rate for the portion of the time utilized to provide the consultation.

8. Therapy sessions consist of a 50-minute "hour". If session last longer than 50 minutes, they will be billed on a pro-rated basis.

9. Fees for individual therapy Monday through Thursday are $135 per 50-minute session. The Fee for marital/ couple therapy is $150/session.

10. **Payment is due when services are received**. Make checks payable to Michael Malloy, LCSW.

11. If for any reason payment for services is not received within thirty (30) days after the services were rendered, there will be a $25 per month carrying charge.

12. I hereby give permission for you to send a letter acknowledging my referral by another professional therapist and to gather any appropriate history that might facilitate the therapeutic process.

13. Should it become necessary to initiate collection procedures on your account, you agree that the venue for the contract is in Williamson County, Tennessee, and agree to pay an attorney's fee or collection agency fee equal to 50 percent (50%) of the amount of the cost of collection.

14. There will be a $25 charge on all returned checks.

I understand the above policies and agree to these provisions.

Signed_____Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that in an attempt to protect the privacy of my identifiable health information, Michael Malloy has established a Privacy Policy as well as guidelines for Privacy Practices within his office. This policy details the use and/or disclosure of information contained in my personal mental health records kept for the purposes of diagnosis, assessment, treatment, payment and healthcare operations. In accordance with HIPPA regulations, a copy of this information has been made available to me while in the office today. Should I choose to have a personal copy, one will be provided at no charge.

Signed_____Date: _____

Office use only:

( ) no copy requested

( ) copy provided

Revised DEC2010

NOTICE OF PRIVACY PRACTICES

MICHAE MALLOY, LCSW, ACSW

Private Practice

This document describes how your mental health information (MHI) as a client of Michael Malloy may be used and disclosed:

A: Commitment to Privacy

I know how important your personal MHI is and am committed to respecting and protecting it. In conducting sessions, I will create notes regarding you and your treatment. I am required by law to maintain the confidentiality of all MHI that identifies you. I am also required by law to provide you with this notice of my legal duties and my privacy practices.

The terms of this notice apply to all records containing your protected MHI that are created or retained by my office. Generally this would include your intake form, office notes, any assessments, homework or personal journals you supply, insurance forms, diagnosis information and appointment receipts. I reserve the right to revise or amend this notice at any time. Any revision or amendment to this notice will be effective for all your past records that I have created or maintained as well as any records that may be created or maintained in the future.

B. Uses and Disclosures of Mental Health Information (MHI)

I may need to use or disclose MHI about you for treatment, payment, or mental healthcare operations. For example:

Treatment: I may use or disclose your MHI to a physician or other healthcare provider where you are also going for treatment.

Payment: I may use and disclose your MHI in the billing process to obtain payment for the services provided to you.

Mental Health Care Operations:

I may use and disclose your protected MHI for mental health care operations, which will include internal administration such as record keeping, billing, appointment setting and reminders, voicemail messages to you and mailings to your home address.

Your Authorization:

In addition to my use of your MHI for treatment, payment or operations, you may also give me written authorization to use your MHI or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your MHI for any reason except those defined in this notice.

Required by Law: I may use or disclose your MHI when I am required to do so by law. This would include reporting child abuse and/or neglect to the authorities authorized by law to receive such reports, and disclosure of your MHI to the extent necessary to avert a serious threat to your own safety and health and /or the safety and health of others.

C. Use and Disclose Requiring Your Written Authorization

I will not use or disclose your confidential information for any purpose other than the purposes described in the notice, without your written permission. For example, I would not supply confidential information to a research organization or to a prospective employer without your signed consent / request.

D. Individual Rights

1. Access

   You have the right to look at or get copies of your MHI, with limited exceptions (i.e., where assessments designate the use by clinicians only). The charge for requested copies is 40 cents per page, $25 per hour for staff time to locate and copy the MHI and the required postage should you want the copies mailed to you.

2. Right to Request Additional Restrictions

   You may request restrictions on my use and disclosure of protected MHI for treatment, payment, or mental health care operations in addition to those explained in the notice. All requests for such restrictions must be made to me in writing. While I will consider all requests for additional restrictions carefully, I am not required to always agree with the additional requested restriction.

3. Right to Receive confidential Communications

   You may request and I will accommodate any reasonable request that you receive protected MHI by an alternative means of communication.

4. Disclosure Accounting

   You have the right to receive a list of instances after April 14, 2003 in which my staff or I have disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities.

5. Right to Amend Your Records

   You have the right to request that I amend your MHI. Your request must be in writing and it must explain why the information should be amended. I may deny your request under come circumstances.

Questions and Complaints

The document is in compliance with requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which is a federal program that requires that all mental health records and other individually identifiable mental health information used or disclosed by me in any for, whether electronically, on paper or orally, are kept properly confidential. If you are ever concerned that I may he violated your privacy rights, or you disagree with a decision I have made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me using the contact information listed at the end of this notice. You also may submit a written complaint to the U. S. Department of Health and Human Services (address provided upon your request).

I do support your right to privacy of your MHI.

Michael Malloy, LCSW
615-376-6411

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