INTAKE PAPERWORK

Jessica Moloney, LMHC, NCC
22 Lawrence Avenue, Suite 106
Smithtown, NY 11787

New Client Form

(Appointment Date:_____ Time:_____) Office Use Only

First Name_____Last Name_____DOB:_____

Address:_____

Phone:_____ Alt. Phone:_____

E-mail:_____

Insurance Information:

Company:_____

ID Number:_____

Subscriber:_____

Date of Birth:_____

Relationship to client:_____

Reason for visit:

Benefit Information: (Office Use Only)

Copay:_____

Deductible: None Already Met Remaining_____(amount)

Number of visits:_____ Authorization #_____

Effective Date:_____ Reference #_____

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. You may revoke this agreement at any time. That revocation will be binding unless action has been taken in reliance on it; if there are obligations imposed by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing below.

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. Psychotherapy can have benefits and risks. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of sadness, anger, depression, anxiety, etc. There are no miracle cures. I cannot guarantee any changes or results. Progress and results are largely determined by the client's dedication to change and efforts made outside the therapeutic time to act upon identified skills. 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. Psychotherapy, specifically Cognitive therapy, often leads to better relationships, solutions to specific problems, and reductions in feelings of distress. After the intake assessment, you will participate in the formulation of your treatment plan and the continued evaluation of this information as therapy progresses. If you have any questions, we should discuss them as they arise. Medication management services are not provided here. Any and all medication & natural remedy recommendations are also merely suggestions, and you will be encouraged to, and agree to, follow up with your medical doctor and/or psychiatrist prior to any medication adjustments.

Appointments, Fees, and Cancellations

The standard meeting time for psychotherapy is 55 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 55-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

Payment is due each session for services rendered. Failure to pay for 2 sessions can result in suspension of therapy until payment is made. The standard fee is $125.00 per hour for services not covered by your insurance. Fee agreements, however, can be made on a sliding scale. Other services in which you may be billed for include report writing, telephone conversations longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatments summaries and time spent performing any other services you have requested. If you become involved in legal proceedings that require my participation, you will be expected to pay for professional time even if I am called to testify by another party. You retain ultimate responsibility for payment even if insurance coverage is involved.

A $10.00 service charge will be charged for any checks returned for any reason for special handling. Cancellations will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If the session can be rescheduled, there will be no charge. Rescheduling, however, is not always possible. Extraordinary circumstances should be discussed with your therapist. If you are late for a session, you may lose some of that session time.

Billing and Insurance

If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon I reserve the right to see legal resources to secure payment. This may involve hiring a

collection agency or small claims court which will require me to disclose otherwise confidential information.
Mental Health services are often covered through your insurance company. I will assist you in accessing your insurance benefits, however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers. You must provide a copy of your insurance card if you wish to use your insurance benefit. You should be aware that your contract with your health insurance company requires that I provide them with information relevant to services that are provided to you including, but not limited to: a clinical diagnosis, treatment plans, summaries, or copies of your clinical record. In any situation, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. Insurance companies claim to keep this information confidential, however, please note, I have no control over what they do with it once it is in their hands. By signing this agreement, you agree I can provide requested information to your carrier.

Telephone Accessibility
If you need to contact me between sessions, please leave a message on my voicemail. Please note that I am only available during office hours and I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

Electronic Communication
I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.
If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:
(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
(2) All existing confidentiality protections are equally applicable.
(3) The technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
(4) Dissemination of any of your identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without your consent.
(5) There are potential risks, consequences, and benefits of telehealth. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, reduction of lost work time and travel costs, and the convenience of meeting from a location of my choosing. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to interruptions, unauthorized access, technical difficulties, and the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the connections are not adequate for the situation.

Confidentiality

The confidentiality of your treatment is maintained and protected by federal law and regulations. Generally, no one will be permitted to access any of your information unless you specifically request, in writing. At the discretion of the therapist, confidentiality may be broken in the event of extraordinary or life-threatening circumstances. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit 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 subpoena for information stated on the subpoena.
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.

<u>The Therapeutic Relationship</u>

The Therapeutic relationship is of utmost importance in your therapy. It is the means by which a therapist and a client engage with each other and effect beneficial change in the client. If, for any reason, you encounter your therapist outside of the therapeutic setting your anonymity will remain and you will not be approached by your therapist. If you choose to attend an event in which you see your therapist is participating in or hosting, you hereby choose to do so on your own accord. If a suggestion is made for you to attend a community event, it is the therapist's professional belief that this event would be of benefit to your treatment. Your decision to attend is your own and will not be considered part of your treatment nor covered under your copayment or insurance reimbursement. If any recommendations are made for you outside of the therapeutic office, you understand and agree that recommendations are just such and are not requirements.

<u>Minors</u>

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential. New York State law gives children of any age the right to independently consent to and receive mental health treatment without parental consent if they request it and it is determined that such services are necessary and if the parent is not reasonably available or requiring parental consent would have a detrimental effect on the course of the child's treatment or a physician both deems it necessary and orders it.

<u>Termination</u>

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from

another referral source.
Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

By signing this form, I certify:

- That I (or my dependent) have insurance coverage and assign all insurance benefits for services rendered to Jessica Moloney, LMHC, NCC, if payable. I understand that I am financially responsible for all charges whether or not paid by my insurance company, including the responsibility for paying applicable deductibles and cancellation fees. I authorize the use of my signature on all insurance submissions.
- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits, and consent to treatment.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Signature **Date**

_____

Relationship (if applicable)

Health Insurance Portability Accountability Act (HIPAA)

Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication 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 that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the New York State Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the New York State Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.

- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of New York State Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

_____ _____

Client/Legal Guardian Signature (*if applicable*) Date

Jessica Moloney

_____

Printed Name

_____ _____

Jessica Moloney, LMHC, NCC Date

HIPPA Consent Form and Acknowledgement for the Notice of Privacy Practices

Client Name (Print):_____ Client Date of Birth:_____/_____/_____

PhoneNumber:_____Email: _____

As a result of the Health Insurance Portability and Accountability Act (HIPPA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release client information except as stated in the HIPPA guidelines or in accordance with your wishes as stated below.

This consent authorizes Jessica Moloney, LMHC, NCC and Mind Body Strength Counseling to send/give my medical information as noted: Leave a voicemail recording including my Personal Health Information on my:

Home phone: Yes No
Cell phone: Yes No
Work phone: Yes No

Leave a voicemail regarding appointment changes, cancellations or confirmations on my home, cell, or work phone number: Yes No

Use of fax, electronic messaging (text/email), etc. for appointment changes, cancellations or confirmations; to transmit treatment, disorder related information, diagnosis information, testing or other results: Yes No

Permit the individual stated below (Personal Representative) to receive test results: Yes No
Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information: Yes No

Name of Designated Personal Representative (Print):_____

Relationship to Client (Print):_____

On this date_____I received and reviewed Jessica Moloney, LMHC, NCC Notice of Privacy Practices, which describes how my medical information maybe used and disclosed. I understand that my medical information may be maintained in an electronic health record and accessed remotely or transmitted securely over the internet.

*If there is any specialty that requires restriction, please document here:_____
_____

I had an opportunity to raise questions regarding this policy and all my questions have been answered
Yes No

The authorization made above will remain effective until such time as I notify Jessica Moloney, LMHC, NCC in writing, by certified mail, of requested changes.

_____
Client or Parent/Guardian/Personal Representative Signature Today's Date

_____
Print Full Name Relationship to Client (print)

Jessica Moloney, LMHC, NCC * 631-240-3178
22 Lawrence Ave., Suite 106
Smithtown, NY 11787

CANCELLATION POLICY

A specific time slot will be reserved for you for services. **24 HOURS NOTICE** is required for all cancellations. A fee of **$50** is billed for less than 24 hours notice and up to **$100** is billed for a no show. This fee is **NOT** billable to your insurance company. **You are responsible for payment.** All subsequent missed sessions without 24 hour notice will be charged at a rate of up to **$125 per session**. If the session can be rescheduled within the same week, this fee will be waived. However, rescheduling is not always possible. Extenuating circumstances will be evaluated on a case by case basis by your therapist.

_____ _____
Signature Date

_____
Relationship (if applicable)