APPLICATION

Date ________________

Name ______________________________
Present Address ______________________________
____
Phone (work) ____________ (home) ____________
Birthdate ____________ Age ____________
Social Security Number______________________

Occupation ______________________________
Gross monthy income ____________________
Employer ______________________________
Employer's address ____________________
Phone ____________

Describe previous employment on back

Email Address: ______________________________
OK to leave message at **HOME:** Yes [ ] No [ ] **WORK:** Yes [ ] No [ ] **CELL:** Yes [ ] No [ ]
Emergency Contact: ______________________________ Phone #:______________________________

PRESENT OR LAST SPOUSE/PARTNER
NAME ______________________________
Address ______________________________
____
Year you were married ____________
Your age when married ____________
If divorced or separated, indicate when, who initiated and why ______________________________
____

Children in the household during marriage

Name	Relationship	Age now/Wherabouts

Describe previous marriages on back of this form

EDUCATIONAL HISTORY (Age 19 and before)
High School ______________________________
Where located ______________________________
When begun ____________ Your age ______
When terminated ____________ Your age ______
Grade/degree obtained ____________________
If you did not finish, why? ____________________

High School ______________________________
Where located ______________________________
When begun ____________ Your age ______
When terminated ____________ Your age ______
Grade/degree obtained ____________________
If you did not finish, why? ____________________

EDUCATION HISTORY (Since age 19)
College/trade school ____________________
Where located ______________________________
When begun ____________ Your age ______
When terminated ____________ Your age ______
Grade/degree obtained ____________________
Special subjects ______________________________
Reason left ______________________________

Other since age 18 ____________________
Where located ______________________________
When begun ____________ Your age ______
When terminated ____________ Your age ______
Grade/degree obtained ____________________
Special subjects ______________________________
Reason left ______________________________

What is the nature of your problem? ______________________________
____
____
____
____
____
____

Revised 4/2022

Michael A. O'Connell and Associates
Specialists in Evaluation and Treatment of Sexual Deviancy, Personality Disorders and Substance Abuse
9800 Harbour Place, Suite 204 · Mukilteo, WA 98275 · (425) 374-8504 · Fax (425) 404-3948 · E-mail: moconnel@mindspring.com
www.droconnelltx.com

OFFICE POLICY

EVALUATIONS

I do not promise to make any particular diagnosis or to reach any particular conclusion when I perform an evaluation. Likewise, I do not promise any particular outcome of treatment. However, I promise to use my best efforts and to perform all of my services for you in a professionally competent manner.

If you request an evaluation of yourself or of a person for whom you are responsible, you are expected to pay for my time regardless of the outcome. You may not withhold payment because the outcome of my evaluation is not what you expected or wanted. Evaluation reports **will not be released** until the evaluation is paid in full.

THERAPY

A successful program of psychotherapy requires of the client: honesty, concern for others, and effort.

Therapy is not something that is done to the client but is a process that the client learns and begins to live.

APPOINTMENTS AND FEES

The fee for evaluation is $200.00 per hour. My fee for forensic work, attending depositions and/or testifying at trial or other adversarial proceedings is $250.00 per hour, including travel time, and time spent waiting to testify. Regardless of the type of service I am asked to perform, the person who signs this Agreement as the responsible party is responsible for paying my fee according to the terms of this Agreement, unless other arrangements have been made in advance and in writing.

The fee for therapy appointments or consultation is $150 based on 50 minutes per session. Your session begins at the scheduled time – not when you arrive. The fee charged for the time spent in testing, report preparation, telephone consultation, court testimony, travel and so forth, should be discussed with your therapist.

Periodically, it is necessary for the therapist to communicate in writing to the referring party, P.O., attorney, etc. The client will be charged an appropriate fee for this service.

Payment should be made at the time of appointment. Interest will accrue at 1.5% compounded interest per month on any balance not paid within 30 days after the charge was incurred. If you have set up payment arrangements with your provider, payment **must** be made monthly. Any account that goes 30 days without receiving a payment will be charged a **late fee of 1.5 percent** of the unpaid balance. This will be charged monthly until payment is received.

Cancellation of, or changing, appointments must be made at least 24 hours in advance. Clients must speak to their therapist when canceling an appointment.

Late cancellation and missed appointments will result in the client being charged a full fee for the session.

Clients will be charged a fee of $45.00 for a returned check.

COLLECTIONS

If an account goes 90 days without payment, it shall be sent for collection. The responsible party shall pay all reasonable costs of collection such as reasonable collection agency charges.

INSURANCE COVERAGE

You are responsible for paying the fee, even if you believe that a third party, such as your insurance company or a government agency, should pay for services. I am not responsible for collecting from your insurance company or from a government agency unless arrangements for collection from a third party have been made with me in advance and in writing. When you enter into this Agreement, you agree to pay my fee, and to seek reimbursement from third parties, such as your insurance company. If you have questions we will, of course, assist you.

After you have paid for my services, or have made arrangements to pay for my services, I will furnish you with information ordinarily necessary to obtain reimbursement from your insurance company. When appropriate, I will furnish you with a diagnosis according to the current Diagnostic and Statistical Manual of the American Psychiatric Association.

Income Tax Records: Fees may be tax deductible as a medical expense if you itemize. You may also deduct your transportation expense to and from this office. Your cancelled check is a sufficient receipt. However, if you wish a summary statement for a given year, this will be furnished on request.

CONFIDENTIALITY

In general, I will not release information about your care without your written consent. However, the law requires the reporting of certain information: suspected child abuse, potential suicide behavior or threatened harm to others. In addition, the court may, in certain situations, subpoena treatment records. (RCW 18.83.110 and RCW 26.44.030 apply)

TERMINATION OF TREATMENT

Either the therapist or the client may terminate treatment at any time. In that case, a report will be made to the referring or supervising party.

AGREEMENT

All agreements are in writing. There are no oral agreements that may supersede this written policy statement. Any modification of the terms of this statement must be in writing and signed by your therapist.

I have read and understood this document. I accept the terms of this Agreement.

Date: ______________

Client: ______________________________

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NOTICE OF PRIVACY PRACTICES

Michael A. O'Connell, PhD, MSW is committed to maintaining the confidentiality of your mental health and financial information, which will be referred to here as "personal information." Examples of your personal information include your name, social security number, address, telephone number, medical/psychosocial history, therapy records, claims information, etc. This Notice of Privacy Practices informs you about how Michael O'Connell may collect, use and disclose your personal information, and about your rights regarding that information. This Notice pertains to you and any dependents in counseling with Michael O'Connell.

MY RESPONSIBILITY TO PROTECT YOUR PERSONAL INFORMATION

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Michael A. O'Connell must take measures to protect the privacy of your personal information only to the extent necessary to conduct the Business of serving you, such as paying your claims. In addition, Michael A. O'Connell takes steps to secure client files and information from unauthorized access. Michael A. O'Connell's privacy policy and practices apply equally to personal information about current and former clients; Michael A. O'Connell will protect the privacy of your information even if you are no longer in treatment here.

HOW MICHAEL A. O'CONNELL MAY COLLECT, USE AND DISCLOSE YOUR PERSONAL INFORMATION

Michael A. O'Connell collects your personal information from these sources: in the course of accepting referral information to assess your eligibility for services with Michael A. O'Connell; from you directly; and/or from individuals or agencies you specifically authorize to share information with Michael A. O'Connell to assure good coordination of your care.

Michael A. O'Connell may use or disclose your personal information *without* your specific authorization for the following purposes:

- Payment: Michael A. O'Connell may use and disclose personal information to process your insurance claims. However, state laws may prohibit Michael A. O'Connell from disclosing certain types of sensitive personal information about you to insurers or to other members of your family without your specific authorization.

- Consultation: One way Michael A. O'Connell assures that you receive the highest quality of care possible, is through the use of professional consultation. Michael A. O'Connell has agreements with consultants that require them to maintain the confidentiality of your personal information. Michael A. O'Connell has a commitment to share as *little* identifying information as possible when seeking consultation.

- As Required by Law: Michael A. O'Connell may use or disclose your personal information when required by federal, state or local law. For example, I may disclose personal information to a health oversight agency, for activities such as audits, investigations, or related to licensure. Personal information may also be disclosed in response to a court order or subpoena, or to law enforcement officials during certain investigations.

- Public Health and Safety: Michael A. O'Connell may disclose personal information about you to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

For all other purposes, Michael A. O'Connell will request your specific authorization in writing, which you may grant or reject. If granted, the authorization remains in effect for ninety (90) days, although you can revoke it at any time by letting Michael A. O'Connell know in writing.

YOUR RIGHTS REGARDING PERSONAL INFORMATION

You have the following rights regarding personal information that we maintain about you:

- Inspection: You have the right to request information and to receive a copy of a record of your personal information.

- Amendment: If you feel the personal information that Michael A. O'Connell maintains about you is incorrect or incomplete, you have the right to request amendment to it.

- Restriction Request: You have the right to request a restriction or limitation on the personal information Michael A. O'Connell discloses about you for treatment, payment or coordination of your care.

- Confidential Communications: You have the right to request that Michael A. O'Connell communicates with you about your treatment at a location that assures utmost privacy. For example, you may ask that Michael A. O'Connell only contact you at your work address/phone.

- Accounting of Disclosures: You have the right to an accounting of disclosures Michael A. O'Connell has made. The first list you request within a 12-month period will be free. For additional lists, Michael A. O'Connell may charge you a reasonable fee to cover copying and supply costs. All of these requests must be made in writing.

CHANGES TO THIS NOTICE

Should any of Michael A. O'Connell's privacy practices change, this Notice will be revised and you will be provided a new copy of it. If you need an extra copy of this Notice or want more information about Michael A. O'Connell's privacy practices, please contact Michael A. O'Connell, PhD, MSW at 9800 Harbour Place, Suite 204, Mukilteo, WA 98275 (425) 374-8504.

REPORTING A PROBLEM

If you believe your privacy rights have been violated, or if you disagree with a decision Michael A. O'Connell has made about a request, you may file a written complaint with Michael A. O'Connell or the Secretary of the Department of Health and Human Services (DHHS). You will not be penalized in any way if you file a complaint about Michael A. O'Connell's privacy practices.

______________________________ ____________________

Signature of Client Date

____

Print name

____

Witness Signature

Michael A. O'Connell and Associates

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General Informed Consent and Agreement

Confidentiality: All information provided by Michael A. O'Connell, Ph.D, MSW, is confidential unless a release of information is received with your signature authorizing disclosure to a specified person or agency as per your request.

However, Washington State law requires that confidential information be released under the following circumstances for the purpose of securing the safety of the client or others:

- If there is a reason to suspect that a child or dependent adult is being abused or neglected or has been within the past several years;
- If a client is considered an imminent danger to him/herself or to someone else and/or is grossly unable to take care of his/her basic life-sustaining needs;
- Under court order, specific information may have to be disclosed;
- Basic information about diagnosis and treatment in order to obtain insurance coverage.

I authorize Michael A. O'Connell, Ph.D, MSW to release necessary information in discerning the status of claims to any third party payer and/or Crime Victims Compensation.

I have read and understand this General Informed Consent and Agreement. I have been given the Notice of Privacy Practices. I agree to participate in treatment with Michael A. O'Connell, Ph.D, MSW.

______________________________ __________________
Signature of client Date

______________________________ __________________
Michael A. O'Connell, Ph.D, MSW Date

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AUTHORIZATION TO EMAIL PROTECTED HEALTH INFORMATION

Authorize email communication

- ☐ I authorize Michael O'Connell and Associates and his staff to email me regarding the course of my care. Email address (*please print*): ______________________________

- ☐ Change email address (*please print*): ______________________________

- ☐ I no longer wish to communicate via email.

Signature required on attached page

- I understand that any email transmission between my provider and me/the client will become part of my medical record. Those email transmissions may be disclosed in accordance with future authorizations.

- I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

- I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that the institution or individuals named above (Michael O'Connell and Associates and his staff) cannot deny or refuse to provide treatment if I refuse to sign this Authorization.

ALERT FOR ELECTRONIC COMMUNICATION

Patients and/or personal representatives who want to communicate with their providers by email should consider all of the following before signing an Authorization to Email Protected Health Information:

1. Email at Dr. O'Connell and Associates can be forwarded, intercepted, printed and stored by others.
2. Email communication is a convenience and is not appropriate for emergencies or time-sensitive issues.
3. Highly sensitive or personal information should only be communicated by email at the client's discretion.

4. Employers generally have the right to access any email received or sent by a person at work.
5. Staff other than the provider may read and process email.
6. Clinically relevant messages and responses will be documented in the client's file at the provider's discretion.
7. Email message content must include the subject of the message in the subject line.
8. Michael O'Connell and Associates will not be liable for information lost or misdirected due to technical errors or failures.

I have read and understand the Alert for Electronic Communications and agree that email messages may include protected health information about me/the client, whenever necessary.

______________________________	______________________
Client's signature	Today's date
______________________________	______________________
Client's printed name	Date of birth

**Please note that this Authorization is not valid unless completed in full. This Authorization will not expire unless revoked in writing. **