Maureen Kearney, Ph. D.
P. O. Box 2224
Rockville, MD 20847-2224

(202) 223-5363

New Client Information

The information you provide in these forms will be kept confidential. Please print out these forms, fill them in, and bring them to our first session. This will help us get started more quickly. If the information changes as therapy continues, especially your contact information and mailing address, please update the data for our records.

Part 1: General Information

Today's date: _____

Date of birth: _____ Your current age: _____

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Sex: _____ M _____ F _____ Other

Home Phone: (_____) _____ SSN: _____

Work Phone: (_____) _____

Cell/Other Phone: (_____) _____

E-Mail: _____

(If you prefer that I not contact you by e-mail, leave blank.)

Marital status: _____ Single _____ Married _____ Committed relationship _____ Separated
_____ Divorced _____ Widowed

Number of children: _____

Their names and ages: _____

Are you employed? _____ Yes _____ No

If yes, name of employer: _____

Job title: _____

Person to contact in case of emergency

Name: _____

Telephone (mobile preferred): _____

E-Mail address: _____

If you are a student, name of school: _____

What areas in your life would you like to focus on in therapy?

_____

_____

_____

Part 2: Brief Mental Health History

Have you previously been in therapy? _____ Yes _____ No

If yes, name of the therapist and approximate dates of service:

_____

Have you ever been hospitalized for mental health reasons? _____ Yes _____ No

If yes, please give the name of the hospital, approximate dates, and why you were hospitalized:

_____

_____

Have you ever been prescribed psychiatric medication? _____ Yes _____ No

If yes, give the dates, and what medicines were prescribed:

_____

_____

_____

_____

Are you taking any other medications? _____ Yes _____ No

If yes, please list them and give the name of the prescribing physician:

_____

_____

_____

How is your current health, in general?

_____ Very good _____ Good _____ Satisfactory _____ Poor

List any physical or health problems you are currently experiencing:

_____

_____

_____

Please provide any concerns you have about your sleep habits, eating problems, or other specific health issues not listed above:

_____

_____

List any recent significant events or stresses in your life:

_____

_____

_____

Do you have panic attacks, specific fears, or anxiety? _____ Yes _____ No
If yes, please give details and the duration:

_____

_____

_____

Are you experiencing depression, grief, or sadness? _____ Yes _____ No
If yes, please give details and the duration:

_____

_____

_____

Do you use alcohol or recreational drugs? _____ Yes _____ No

If yes, please give frequency and amounts:

_____

_____

Please describe mental health issues that your family members have experienced (e.g., depression, suicide attempts, alcohol or drug abuse, etc.):

_____

_____

_____

If you were referred to me for therapy, by whom? _____

Part 3: Insurance information

Insurance carrier: _____

Your ID for the policy: _____

Are you the subscriber? _____ Yes _____ No

If no,

Name of Subscriber: _____

Address of subscriber: _____

_____

_____

Subscriber's phone: _____

Subscriber's: Sex _____ M _____ F; Date of birth: _____

Your relationship to subscriber: _____

Are you covered under another insurance policy? _____ Yes _____ No

If yes, please provide the above information for the other policy.

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Consent Form

Welcome to my practice. This document contains important information to help you understand my professional services and business policies. Please read this information carefully and feel free to ask about anything that you would like me to discuss further.

1. GENERAL INFORMATION

A. Confidentiality.

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can release information about our work to others only with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I must make a report to the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I am obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to discuss it fully with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

B. Initial Appointment.

The first and the next few sessions are the time during which the therapist and patient:

- discuss the patient's presenting problem, current and past personality functioning, family background and history, and goals of treatment;
- determine whether we can comfortably work together and/or whether another referral would be appropriate;
- determine the appropriate frequency of sessions (once or twice a week, biweekly, etc).
- consider other recommendations, suggestions, or needs.

C. Client Rights.

You have the right to ask questions about my philosophy of therapy and the procedures used. You have the right to end therapy at any time without moral, legal, or financial obligation beyond payment due for completed sessions. Should you decide *between* sessions to withdraw from therapy, I ask that you attend one more session to discuss your reasons. [Therapy termination can sometimes be the result of misinterpretation, miscommunication, or the painfulness of the material being dealt with.] I

encourage open communication before a final decision is made. Should you decide to terminate therapy, but wish to continue with someone else, I would be happy to provide you with names of other qualified therapists.

D. Other.

If a problem of any type (*e.g.,* financial, scheduling, therapy approach) arises during the course of our work, please bring it up so that it may be discussed/negotiated/worked through.

2. FEE INFORMATION

A. Fees and Insurance.

For individual therapy, my fee is $175 per 55-minute session, beginning with the first session. Charges are prorated for longer or shorter sessions. I charge this same hourly rate for other professional services you may need, such as report writing, telephone conversations lasting more than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If I participate in a plan offered by your insurer, your per-session fee may be less than $175, based on your co-pay requirements. Also, please be aware that you may need to meet your deductible at the beginning of the year, in which case the full fee for the session would apply. The payment will be collected at the time of each service.

I will file claims for insurance contracts in which I participate. You will have to file a claim with your insurer if you have a plan in which I do not participate. To do so, just attach the monthly bill to the insurance form and send it to the insurer (make a copy of the bill for your records). The information on the bill is usually sufficient for processing claims. I will provide any additional information your insurer may require at no charge.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.*** It is important to remember that you always have the right to pay for my services yourself to avoid these problems (unless prohibited by your insurance contract).

B. Payment.

All fees are payable at the time the service is rendered. A therapy summary will be sent monthly, showing charges and payments during the month. This may be used for insurance purposes. ***Fees are payable in full without regard to insurance reimbursement.*** A late-payment fee of 1.5% of the amount due is charged monthly on overdue balances. If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. If this becomes necessary, you will be responsible for all collection fees, court costs, and reasonable attorney fees. In case of nonpayment of bills, you agree to waive any rights of confidentiality only to the extent necessary to collect such unpaid bills.

C. Missed Appointments.

Scheduling presents a special problem in private therapy, because once a given hour is allocated for a particular client, it usually cannot be reallocated to another on short notice. For this reason, I will need to charge you for missed sessions which are cancelled less than 24 hours before the appointment time. Of course, illness and personal emergencies are exceptions, and will be treated on a per-case basis. **Please note** that insurance companies will not pay for missed sessions; when they are billed, the client is responsible for the entire fee of $175.

D. Contacting me.

I am often not immediately available by telephone, especially if I am with another patient. When I am not available, my telephone is answered by voicemail that I monitor regularly. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health professional on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

E. Telephone Sessions.

Occasionally, telephone contact is needed when issues arise in between regularly-scheduled sessions. Phone calls with clients or collaterals (e.g., relatives, attorneys, etc.) extending more than 10 minutes are billed at the normal hourly rate for individual sessions. The fee is prorated for the duration of the conversation.

F. Agreement.

I have read the terms and conditions set out in this document, and I agree to be bound by them.

Signature:_____ Date:_____

Printed name: _____

Maureen Kearney, Ph. D.
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INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology
Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may -arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications
We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or, software to take part in telepsychology.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods should not be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental-health professional on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Consent Form still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology
From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (202-223-5363).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees
The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records
The telepsychology sessions shall not be recorded in any way. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent
This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____
Client Date

_____ _____
Therapist Date

Maureen Kearney, Ph. D.
P. O. Box 2224
Rockville, MD 20847-2224

Please sign and date below.

Consent to use and disclose your health information

This form is an agreement between you, _____and me, **Maureen Kearney, Ph. D.** When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here .

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read that Notice before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from me by calling me at **(202) 223-5363.**

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client Date

Please read and keep this copy for your records.

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_____ _____

Signature of client Date

Maureen Kearney, Ph. D.
P. O. Box 2224
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Notice of Privacy Practices

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

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. However, we cannot cover all possible situations so please talk to our Privacy Officer (see the end of this notice) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called, in the law, health care **operations**. After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the 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 have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, who is **Maureen Kearney, Ph. D.,** and can be reached by phone at **(202) 223-5363.**

The effective date of this notice is April 14, 2003