MLZ TheraP, PLLC.
Marilyn Wiley, MSPsych
Child, Family, & Adult Therapy
Certified Life Coach/Time Management
Consultant

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520.431.7491

Please take time to fill out the following forms with as much information and detail possible. All of the information is private and confidential and will help me to provide you with the best possible services.

I am happy to answer any questions you have at the time of intake. I look forward to meeting you soon.

MLZ TheraP, PLLC.

Client Contact Information

YOUR COMPANY NAME/LOGO

Note: All personal information is held securely in accordance with the appropriate legislation, is confidential and treated appropriately.

Client Information

Mr/Mrs/Miss/Ms/Other _____ Last name _____

Name you like to be called _____

Address _____

_____

Telephone Numbers/Contact Details

Home _____ Work _____

Cellphone _____ Pager _____

Fax _____

Email/s _____

Preferred Contact Mode/s _____

Employment Information

Occupation _____

Employer Name _____

Personal Information

Date of Birth _____ Marital Status _____

No. of Children _____

Significant Other's Name _____

Significant Others Date of Birth _____

Significant Dates (eg. Wedding anniversary) _____

_____

Name(s) and Age(s) of Child(ren) _____

_____

Personal Information

Who do you live with?_____

_____

Any concerns about your current living situation or environment? _____

_____

Are you safe in your home? Yes No (please explain) _____

_____

Have you experienced any recent significant life changes (death in family, auto accident, divorce, birth of child, etc)?_____

_____

Who were you raised by?

_____

Briefly describe your relationship with your primary caregivers.

_____

_____

_____

Were there any significant childhood events that caused difficulties (loss, divorce, abuse, illness, etc)? (Please explain)

_____

_____

Have you experienced abuse (physical, sexual, verbal) in childhood or adulthood? No Yes (please explain)

_____

_____

Are there any family (immediate or extended) dynamics that add stressors to your life?

_____

_____

Do you currently or have you ever had suicidal thoughts or attempts? Please explain

_____

_____

History of drug and/or alcohol abuse and/or use? No Yes (please explain)

_____

_____

Are you currently involved with the court or legal system for any reason? No Yes (please explain)

_____

_____

Who or what are your support systems (friends, family, church, etc)?

_____

_____

What are your strengths, interests, hobbies?

_____

_____

Is there any additional information you would like to be sure I know or address to best help you?

_____

_____

_____

INFORMED CONSENT

Statement of Confidentiality and Client Rights

Information may be released to designated parties by written authorization of clients or legal guardians. Therapists are required to report suspected past or present abuse or neglect of children, dependent adults, and elders, to the appropriate authorities based on information provided by the client or collateral sources. Therapists are required to release information obtained from clients or from collateral sources (other individuals involved in a client's psychotherapy, such as parents, guardians, spouses) to appropriate authorities to the extent to which such disclosure may help to avert danger to a client or to others, e.g.; imminent risk of suicide, homicide, or destruction of property that could endanger others. If a client is using confidentiality as a means of avoiding legal punishment, the therapist must break confidentiality because the therapist may not aid or abet committing a crime. Therapists reserve the right to release financial information to a collections agency, attorney, or small claims court for delinquent client accounts.

Except for the limitations described, information about you and/or your family will not be released to others without my verbal and written permission.

I have received a copy of my rights according to HIPPA and understand these rights.

I hereby understand the above statement of confidentiality.

Signed _____ Dated _____

Counseling Fees and Financial Statement

Fee: 100.00 per initial intake and assessment.
60.00 per 60 minute session.

I understand and accept financial responsibility for services provided. I further understand that I am responsible for the full fee and I guarantee payment for all charges incurred with MLZ TheraP, PLLC.

- **Initial assessments are 60 minutes in length.**
- **Sessions are 60 minutes in length. When working with a minor, sessions are 50 minutes allowing the last 10 minutes to discuss progress and future treatment goals with parents and guardians.**
- **If a phone consultation is necessary, I am happy to schedule one. Otherwise, phone calls will be kept to 5 minutes. Phone calls exceeding 5 minutes will be billed at $15 in 15 minute increments. Payment will be collected at your next appointment.**
- **A $45 fee is charged for appointments missed or if not canceled 24 hours in advance. Please note this policy is enforced.**
- **Phone calls will be returned in 24-48 hours. In case of a crisis you can call 911 or the 24 hour crisis line at 1.800.631.1314.**

I hereby agree to the above statement of fees and financial liability

Signed _____ Dated _____

HIPPA NOTICE OF RIGHTS AND PRIVACY

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

Effective date: April 14, 2003. MLZ TheraP, PLLC only releases information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes the policies related to the use and disclosure of clients' healthcare information.

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes. Your healthcare information may be used and disclosed to appropriate sources for the following reasons:

Treatment:

- Provide, manage or coordinate care
- Consultants and referral sources

Payment:

- Verify insurance and coverage & process claims and collect fees

Healthcare operations:

- Review of treatment procedures, review of business activities
- Certification, staff training, and/or compliance and licensing activities

Other uses and disclosures without your consent:

- Mandated reporting, emergencies, criminal damage, appointment scheduling, treatment alternatives, and as required by law

Client rights: As a client of mental/behavioral health services you have the following rights (more detailed information of most of these categories is provided in your consent to treatment):

Right to request where we contact you: Please circle

- Home Work Cell Email Other _____

Right to release your medical records:

- Written authorization to release records to others
- Right to revoke release in writing (revocation is not valid to the extent that the counselor has acted in reliance on such previous authorization)

Right to inspect and copy your medical billing records:

- Right to inspect and receive a copy of your records (counselor may deny this request). Charges for copying, mailing, etc. apply

Right to add information or amend your medical records:

- May request to amend your record, counselor has 30 days to decide & counselor may deny the request. If denied, you have the right to file a disagreement statement. Disagreement and the counselor's response will be filed in the record. Amendment request must be in writing

Right to Accounting of disclosures:

- For a six year period beginning with date the counselor came in to compliance (no later than 4/14/03) Exceptions: Disclosure for treatment, payment or healthcare operations, disclosures pursuant to a signed release, disclosure made to client, disclosures for national security or law enforcement.

Right to request restrictions on uses and disclosures of your healthcare information:

- Must be in writing & counselor is not obligated to agree

Right to complain:

- Please contact the counselor first in person or in writing. If not satisfied, you have the right to complain to the U.S. Dept. of Health and Human Services

I understand my rights: Signature_____Date _____

SIGNATURE ON FILE & ASSIGNMENT OF BENEFITS

INSURANCE: I request that payment of authorized insurance benefits be made on my behalf to Marilyn Wiley for services furnished to me by Marilyn Wiley. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Marilyn Wiley accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the insurance carrier.

OTHER INSURANCE: I understand that Marilyn Wiley maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Marilyn Wiley has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Marilyn Wiley if I belong to a plan that does not appear on the above-mentioned list.

NON-COVERED SERVICES: I understand that Marilyn Wiley contracts with health care service plans. (i.e., HMO's, PPO's) Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plan's not to be covered.

Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Marilyn Wiley to obtain necessary health care service plan authorizations.

_____
Beneficiary or Guardian Name (print)

_____ _____
Beneficiary or Guardian Signature** Date

** If an authorization is signed by an individual's personal representative, the representative's authority is based on:

_____ (e.g., state law, court order, etc.)