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

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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) _____

_____

Child/Adolescent Intake Information

Child's Name:_____ Child's Primary Address:_____
Zip_____ Child's Gender: Male Female
Date of Birth: / /
Age:_____ Child's Ethnicity:_____
Religious preference (optional):_____
In case of emergency, contact:_____Phone _____

INSURANCE INFORMATION

Insured's Name_____Relationship to Patient _____

Insured's DOB_____Policy ID_____Group # _____

Insured's Social Security _____

GENERAL INFORMATION

Current living arrangements: _____
(biological parents, joint custody, single parent, adoptive parents, blended family, etc…)

Child's Legal Guardian(s): _____

Has your child ever seen a mental health professional (psychiatrist, psychologist, other)?
Yes No
If yes, What were the issues being addressed?
_____

Has your child been hospitalized or confined for mental health concerns? Yes No
If yes: When_____Where _____

How were you referred to counseling? _____

Are you seeking services because your child has experienced a trauma? Yes No
If yes, please provide a brief explanation _____
_____
_____

Are you seeking services because your child is a victim of a crime? Yes No
If yes, please provide a brief explanation _____
_____
_____
Did it result in legal action? Yes No If yes, please explain _____
_____

If yes, is involvement with the legal or judicial system currently ongoing? Yes No
If yes, please list names of any lawyers, detectives, & other persons involved _____
_____
Is your child currently on probation? Yes No If yes, Probation Officer: _____

School Child Attends:_____Grade _____
Current Teacher(s):_____Phone Number _____
Is your child receiving special education or other services? Yes No
If yes, please explain
_____

INFORMATION ON CHILD'S MOTHER

Mother's Name:_____
I am:_____biological mother_____stepmother_____adopted mother _____

Full _____ Address: _____
Home Phone:_____
Cell Phone: _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)

Any history of or current emotional or behavioral problems: Yes No
If yes, please explain_____
History of alcohol/drug/substance abuse: Yes No
If yes, please explain _____
History of family violence: Yes No
If yes, please explain _____
History of criminal activity: Yes No
If yes, please explain _____
Marital Status:_____

INFORMATION ON CHILD'S FATHER

Father's Name:_____
I am:_____biological Father_____stepfather_____adopted father _____

Full _____ Address: _____
Home Phone:_____
Cell Phone: _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)

Any history of or current emotional or behavioral problems: Yes No
If yes, please explain_____
History of alcohol/drug/substance abuse: Yes No
If yes, please explain _____
History of family violence: Yes No
If yes, please explain _____
History of criminal activity: Yes No
If yes, please explain _____
Marital Status:_____

List by Household your child's current family, beginning with the oldest member and include the child: **Primary Household** (anyone who currently lives with child)

Name Age Gender Relationship to child (include step, half, etc.)

_____

_____

_____

_____

Second Household (non-custodial or extended family – if applicable)

Name Age Gender Relationship to child (include step, half, etc.)

_____

_____

_____

Currently involved in a custody dispute: No Yes (If yes, explain)

_____

_____

If divorced, circle the number which best describes your relationship with your ex-spouse

Hostile_____Frustrating_____Friendly _____

What is the current custody arrangement? _____

CHILD'S HEALTH

What is the child's overall Medical Health?___Good___Fair____Poor

Has your child ever seen a psychiatrist? Yes No

Is child currently seeing a psychiatrist? Yes No (If yes, list name, address and phone):

_____

Physical Disability: Yes No If yes, explain _____

Chronic Illness: Yes No If yes, explain _____

Terminal Illness: Yes No If yes, explain _____

Please list current medications your child is taking and what they are prescribed for:

_____

_____

_____

Has your child has been diagnosed? No Yes If yes, what is the diagnosis and who gave the diagnosis_____

EARLY CHILDHOOD DEVELOPMENT

Raised by: _____

Do you feel a strong/secure bond was formed with child and primary care givers during pregnancy? Yes No If No, please explain: _____

_____

_____

Do you feel a strong/secure bond was formed with child and primary care givers during from birth to 2/3 years of age? Yes No If No, please explain

_____

Stressors in the Family (Mark all that apply with a **C** if current and **P** if Past, explain if applicable)

_____Chronic illness of family member _____
_____Death of significant person _____
_____Domestic Violence_____Witness or Victim or Both (Cirlce)
_____Family member absent_____Whom? _____
_____Family member's disability/major accident/illness _____
_____Family member emotional problems _____
_____Family member suicide _____
_____Financial problems
_____Moved a lot
_____Parents arguing frequently
_____Parents divorced
_____Other

Has your child been abused?____Physically_____Emotionally_____Sexually

Has your child been neglected?_____Physically_Emotionally

History of interpersonal problems includes: (check all that apply)
___Aggressive behavior_____Bullied____Taken advantage of_____Frequent arguments
____Temper outbursts_____Loner____Poor social skills

Family Atmosphere (circle the number that best describes how you view your child's current family atmosphere)

Very lenient	1	2	3	4	5	Very strict
Non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

Family Support System (such as church, friends, relatives, school)
Poor support 1_____2_____3_____4_____5 Considerable support

Average number of hours per day child uses computer/video games _____
Average number of hours per day child watches TV _____

CURRENT CONCERNS

Indicate severity of up to 10 items that currently apply to your child. (I-mild; 2-moderate; 3-severe) Circle the item that you see as the most significant issue.
_____Abuse (physical, emotional, sexual)
_____Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc.)
_____Bed wetting daytime wetting, soiling or related problems
_____Career Decisions

_____Disturbing memories (past abuse, neglect or other traumatic experience)
_____Drug or alcohol use (both legal and illegal drugs)
_____Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
_____Family or Stepfamily relationship problems
_____Feeling angry or irritable
_____Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
_____Feeling guilty or shameful
_____Feeling sadness or depression NOT related to grief
_____Feeling sadness or depression related to grief
_____Gang related concerns (explain) _____
_____Health concerns (physical complaints and/or medical problems)
_____Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
_____Learning/Academic difficulties
_____Non-family relationship problems (teachers, peers, etc.)
_____Parent-Child relationship (discipline, adoption, single parent. etc.)
_____Personal Growth (no specific problem)
_____Religious or Spiritual concerns
_____Sexual concerns (excessive masturbation, inappropriate acting out)
_____Sexual identity concern
_____Sleep problems (nightmares, sleeping too much or too little, etc.)
_____Speech problem (not talking, stuttering, etc.)
_____Suicidal Ideation (thoughts of death, wanting to die)
_____Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
_____Unusual experiences (loss of periods of time, sensing unreal things….)
_____Other (explain) _____

****Remember to circle the most significant issue*

When did you first become concerned about this issue? _____
How have you attempted before now to deal with this issue? _____
_____
What do you enjoy most about this child? _____
_____
What do you find most difficult about this child? _____
What are your child's interests? (include general interests, specific toys they like to play with, etc) _____
_____
Is there anything else you would like me to know about your child or your family that may be helpful in working with your child? _____
_____
_____

Coaching Contract

Client Name: _____

This agreement, between coach _____ and the above-named client will begin on _____ and will continue for a period of _____ months ending on _____.

Fees

The fee for the initial meeting is $_____ and the fee for the following meetings is $_____. These fees will be paid in advance.

Alternatively, this is a _____ package for a period of _____ months including _____ appointments per month for _____ minutes at a time.

Additional appointments can be scheduled as needed.

If you need to cancel an appointment, please provide at least 24 hour's notice or unfortunately, it will be necessary to charge you for the appointment.

Services

The services to be provided by the coach to the client are face-to-face or telephone-coaching, as agreed jointly with the client. Coaching may address specific personal projects, business successes, or general conditions in the client's life or profession. Other coaching services include value clarification, brainstorming, identifying plans of action, examining modes of operating in life, asking clarifying questions, and making empowering requests or suggestions for action.

Throughout the working relationship, the coach will engage in direct and personal conversations. The client understands that successful coaching requires a co-active collaborative approach between client and coach. In the coaching relationship, the coach plays the role of a facilitator of change, but it is the client's responsibility to enact or bring about the change.

If the client believes the coaching is not working as desired, the client will communicate and take action to return the power to the coaching relationship.

You are very much encouraged to read the Member's download document titled, *"What You Need to Know"* as a way of more fully understanding what coaching is about and how to get the most out of it.

Prior History

The client also agrees to disclose details of the past or present psychological or psychiatric treatment. Coaching and counselling are not the same as described on the website www.drdarryl.com in the Member's download document *"What You Need to Know"* and as such, there needs to be a clear distinction between the two.

Although I am a registered psychologist trained in counselling or therapy, I do not engage in therapy with my coaching clients. In entering into

the coaching relationship, and signing the agreement, you are agreeing that if any mental health difficulties arise during the course of the coaching relationship, you will notify me immediately so that I can discuss with you an appropriate referral.

Privacy

The client can, at any point in the coaching session, declare his/her preference not to discuss a specific issue, by simply stating that they would rather not discuss this issue. The coach agrees to respect this boundary and will not attempt to forward the conversation further along those lines.

Confidentiality

The coaching psychologist will work within the professional ethics and guidelines as designated by both the International Coaching Federation (see www.coachfederation.org) and by the Australian Psychological Society (see www.aps.psychsociety.com.au) . Copies of the ethical guidelines are available on the websites. All information about the coach / client relationship will remain strictly confidential except in very rare circumstances where decreed by law; ie. where the court might issue a subpoena for the file or information.

If you wish for me as your coach to speak to someone outside our interactions, then you need to give me written permission (original letter, fax or email) to do so. Exceptions to confidentiality of course relate to circumstances such as intent to seriously harm someone, child abuse etc. Otherwise, all your information is confidential.

It is also important to note that in some situations, it is important to be aware of the use of technology in that for some clients, there is a risk in using certain media such as the internet, mobile phones and cordless phones. If you use these to communicate with me, then I will assume that it is appropriate to continue to do so in my interactions with you.

Termination

The coach and client agree to provide each other with two week's notice in the event that it is desired to terminate coaching. Otherwise, the coaching will continue for the duration of the contracted period.

I believe that each of my clients is a unique, creative and responsible person who is in charge of moving their own life forward. I very much look forward to working with you.

Our signatures on this agreement indicate full understanding of and agreement with the information outlined above.

_____ _____

Coaching Client Date

_____ _____

Executive & Personal Coach Date

Continuing Coaching Accreditation

As a separate issue, it is also important to inform that in terms of continuing accreditation as a coach, the International Coach Federation (ICF) (which is the international accrediting body for coaching) has a policy of verifying that coaching has been conducted. As such, at times, they may ask for the phone number and email of clients to authenticate the claim that I have been conducting coaching. Of course, they may not contact you at all, but you would need to be willing to be contacted if necessary. To that end, you would need to be willing to have your phone number and email listed, if indeed, the ICF chose to verify my claims of coaching.

If you are happy to have your phone number and email provided to ICF if they asked for it, please sign below that you are in agreement that this could occur.

_____ _____

Coaching Client Date

_____ _____

Executive & Personal Coach Date

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

_____ _____

Client's 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.)