



DEMOGRAPHIC INFORMATION :

Client's Full Name as Insured: _____ DOB: ___/___/___
 Client's Name: _____
 Address: _____ City: _____ State: ___ Zip: _____
 Phone: _____ Email: _____
 Preferred contact method: Phone Email Either
 Insured Gender: Female Male
 Identified Gender: Female Male Other Please Specify: _____
 Pronouns: She/Her/Hers He/Him/His They/Them
 Employer: _____ Occupation: _____
 School: _____ Grade: _____

PLEASE LIST OTHER PERSONS RESIDING WITH THE CLIENT: Use reverse if necessary

Name: _____ Age: _____ Relationship to Client: _____
 Name: _____ Age: _____ Relationship to Client: _____
 Name: _____ Age: _____ Relationship to Client: _____

Type of service(s) requested:	<input type="checkbox"/> Individual Therapy <input type="checkbox"/> Family Therapy	Current Court Involvement? Services court ordered?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
History of previous therapy services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Involved with a psychiatrist currently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any health needs or concerns to be aware of?		Current Diagnosis:	
How were you referred to me?		Name of psychiatrist:	
List Current medications (if any):		Date of last visit:	

IF THE IDENTIFIED CLIENT IS UNDER 18 YEARS OLD:

ARE YOU THE LEGAL GUARDIAN? Yes No

MOTHER FATHER OTHER: _____
 Last: _____ First: _____ MI: _____
 Address: _____ City: _____ State: ___ Zip: _____
 Home Phone: _____ Work Phone: _____ Alt Phone: _____

EMERGENCY CONTACT INFORMATION/OTHER PARENT:

I volunteer to provide the below contact information and authorize Murphy Counseling and Therapy Services, LLC to contact any listed individual on my behalf in the event of an emergency. *If there are parents with separate contact information, please provide the additional information below.*

- 1. NAME:** _____
 Relationship to Client: _____ Address same as Client: ___ Yes ___ No
 Address: _____ City: _____ State: ___ Zip: _____
 Phone (Include area code): _____



**Verification of Receipt of Psychotherapy Practice Information,
Informed Consent, Consumer Rights Statement & Notice of Privacy Act**

I verify that I have been provided with a written informed consent for psychological services- including written information regarding risks and benefits of services, limitations of confidentiality & informed about my rights and responsibilities as a client, along with a written Notice of Privacy Rights under HIPPA and a general statement about consumer rights. I understand that Murphy Counseling and Therapy Services; Emily Murphy MS, LMHC is willing to answer any questions I may have about these written documents.

Initial & Date: _____

By signing this agreement you:

- state that you have read and understand the information presented in the informed consent
- hereby voluntarily consent to assessment and/or treatment at Murphy Counseling and Therapy Services
- will abide by the terms stated above
- confirm you have been given a copy of your HIPPA privacy rights

Client/Guardian Signature

Date

Printed Name

Date of Birth

Emily Murphy MS, LMHC, Signature

Date



Authorization for Release of Information to Insurance Company

I authorize Murphy Counseling and Therapy Services to release billing information which may include client name, date and type of services, diagnoses codes, substance abuse information and/or treatment plans to my insurance company/ies for the purpose of: collecting insurance benefits or for authorization of additional sessions for:

Client Name _____ Date of Birth _____

- I understand that I have the right to inspect the information released through this authorization and such an inspection will occur in a meeting with Emily Murphy.
- I understand that I may revoke this authorization by providing a written revocation.
- I also understand any information released prior to the revocation may be used for the purpose(s) listed above.
- A photocopy of this authorization shall have the same force as the original.
- This release shall be valid for one year following our last appointment, unless otherwise restricted.

Signed: _____ Date: _____

Witnessed: _____ Date: _____

Emily Murphy, Murphy Counseling and Therapy Services

Insured's — Name and Date of Birth	
Insurance Company-	
Insurance Company Phone Number:	
Policy Number:	
Group Number if applicable	
Date coverage started if listed on card	
Co pay listed on card	

**** Murphy Counseling and Therapy Services will need to photocopy your insurance card at your first session****

Although your Health insurance MAY cover all your fees, ultimately it is your responsibility to cover all your costs. Some plans require preauthorization before your first visit. It is YOUR responsibility to obtain this authorization. Mental Health benefits may differ from your medical benefits so it is essential that you have researched your mental health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will be responsible for the full cash payment at the time of service. Further, if your insurance carrier determines that the services received are not medically necessary, you will be responsible for full payment of your accrued fees.



INFORMED CONSENT

Welcome to Murphy Counseling and Therapy Services.
Please discuss any questions or concerns with Emily Murphy MS, LMHC.

SERVICES: You are eligible for counseling services, assessment, and/or referral consultation services from Murphy Therapy & Counseling Services.

TERMINATION OF SERVICES: The following actions can result in the termination of services; failure to respond to the attempts to contact by Emily, frequent late or missed appointments, harassment or abusive behavior of any nature (verbal, physical, sexual) towards Emily or others in the office building, no longer insurance and/or medicaid eligible and unable to pay out of pocket, or voluntary termination.

SESSION FEES: Your initial session when your full history is gathered is \$150. Charges for individual sessions are typically \$100 for an individual session and \$120 for a family session. All out of pocket fees, including any co-pays or deductibles, are due at the time of your session.

INSURANCE: *Although your Health insurance MAY cover all your fees, ultimately it is your responsibility to cover all your costs. Some plans require preauthorization before your first visit. It is YOUR responsibility to obtain this authorization. Mental Health benefits may differ from your medical benefits so it is essential that you have researched your mental health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will be responsible for the full cash payment at the time of service. Further, if your insurance carrier determines that the services received are not medically necessary, you will be responsible for full payment of your accrued fees.*

LATE/CANCELATION/NOSHOW FEES: An appointment missed without cancellation will result in a **\$ 50 no show fee** for individual sessions for the first missed session and after that the full \$150 rate. **A late cancel fee of \$50 may apply to individual sessions not cancelled 24 hours in advance.** These fees must be paid prior to me holding your subsequent scheduled appointment/s or scheduling new appointments. If a client is more than 15 minutes late to a session the session will be canceled and client is responsible for the no show fee. If there is a pattern of multiple missed, canceled, or late appointments therapy may be terminated.

ADDITIONAL FEES:

Any requests for reports should be made in writing/email 14 days prior to when the report is needed in order to avoid any charges. Reports needed sooner than 14 days may be subject to a fee of \$50 per hour spent preparing the report. Coordination of services, either in person or via phone, may be subject to a fee of \$100 per hour billed in 30 minute increments. Phone calls with clients or parents lasting longer than 10 minutes are subject to the above fee.

EMERGENCY PROCEDURE: In the event you have a behavioral or mental health emergency please contact 911 or your local hospital. Emily is not typically available outside of business hours. Once 911 has been contacted, then please make an effort to contact Emily.

HOURS OF OPERATION: Murphy Counseling and Therapy Services is open from 9am to 5pm, Monday through Thursday. Hours for Murphy Counseling and Therapy Services may vary depending on need and preference.



OFFICE SPACE NOTIFICATION: Murphy Counseling and Therapy Services shares office space with JMG Therapy & Counseling Services. Please be aware that at time persons from either agency may be the one to greet you in the lobby. JMG Therapy adheres to the same privacy practices as Emily and Murphy Counseling and Therapy Services.

OFFICE SPACE NOTIFICATION: Emily engages in professional case consultation with therapists Andrea Gustafson LISW and Amanda Ackerman MA, LMHC. Both therapists adhere to the same privacy and ethical practices as Emily. Efforts are made to limit the amount of information given during consultations. If you are aware of a conflict of interest with either therapist please let Emily know so alternative consultation can be arraigned.

PRIVACY OF INFORMATION: Both professional ethics and the law require strict procedures to keep your information confidential. If you are 18 years of age or older, all information you share at Murphy Counseling and Therapy Services is privileged and treated confidentially according to state and federal law. The law requires that I obtain your signature acknowledging that I have provided you with this information. Emily will not release personally identifiable information without your prior written permission. There are some situations, however, in which she may legally and ethically be obligated to release counseling information, even without your consent. These include:

- Situations in which there is a clear and present danger that someone's life, health or safety is at risk.
- Cases of apparent abuse of a child or a dependent adult.
- Other situations required by state or federal law, such as subpoenas and court orders.
- Disclosures required by health insurers or to collect overdue fees.
- You should be aware that Murphy Counseling and Therapy Services may need to share protected information with other professionals/partners for clinical/scheduling/billing issues. All these individuals have signed a HIPPA business agreement form agreeing to protect your private information and comply with all HIPPA guidelines.
- If you file a complaint against Murphy Counseling and Therapy Services I may disclose relevant information in order to establish any necessary defense/response.

If you are under 18, you and Emily will discuss communication of information with your guardians

SMS TEXT MESSAGING: Murphy Counseling and Therapy Services might use SMS text messaging, from time to time, for certain types of communication with you, including potentially for administrative issues, such as billing, or for health-related issues, such as care reminders.

You agree to receive (you "opt in" to receiving) SMS text messages from Murphy Counseling and Therapy Services, related to services that we are providing to you. Message and data rates may apply, and message frequency varies. You may text us STOP at any time to opt out of receiving SMS text messages from us. You may text us HELP at any time to receive help. SMS text messages from Murphy Counseling and Therapy Services may originate from our organizational phone numbers, including: 515-777-1208

There may be terms in other agreements between you and us that also apply to our organization's use of SMS text messaging, such as general terms related to privacy and data handling for our organization that are not specific to SMS text messaging. You agree that you have reviewed all agreements that we have provided you.

RISKS ASSOCIATED WITH COUNSELING: Therapy has been proven to be beneficial for most individuals. The minimal anticipated risks may include the experience of intense and unwanted feelings including sadness, fear,



anger, guilt, or anxiety. While possibly uncomfortable temporarily, these feelings may be an important part of the therapy process.

MURPHY COUNSELING AND THERAPY SERVICES AND THE LEGAL SYSTEM: Emily does not offer forensic expert testimony or custody testimony. However, you can, and often should, seek therapeutic support at Murphy Counseling and Therapy Services as you work through a legal concern. If there is current court involvement, or court involvement occurs after therapy starts, an additional informed consent will be given outlining specifics of court related situations.



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.

PROTECTED HEALTH INFORMATION: In the course of treatment, information regarding your care may be created and/or received. Information which can be used to identify you and which relates to your past, present or future physical or mental condition, receipt of care or payment for care is considered protected information and is protected by federal and state law.

Federal law imposes certain obligations and duties upon providers of services with respect to your protected information. Specifically, I am required to:

- Provide you with notice of my legal duties and policies regarding the use and disclosure of your protected information;
- Maintain the confidentiality of your protected information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your protected information, unless under the law we are authorized to release your protected information without your authorization.
- Allow you to inspect and copy your protected information;
- Act on your request to amend protected information, although I am not required to amend the protected information, within sixty (60) days and notify you of any delay which would require me to extend the deadline by the permitted thirty (30) day extension;
- Accommodate reasonable requests to communicate protected information by alternative means or methods;
- Notify you of any breach in your protected health information with sixty (60) days of discovery; and
- Abide by the terms of this notice.

HOW YOUR PROTECTED INFORMATION MAY BE USED AND DISCLOSED

Generally, your protected information may be used and disclosed only with your express written authorization. This written authorization includes to whom the information may be disclosed, what information may be disclosed, and for what purpose. You may revoke this authorization at any time, although any information released prior to the revocation may be used as stated on the consent.

There are some exceptions to this general rule. The following explains how Murphy Counseling and Therapy Services, LLC will use or disclose your protected information without your authorization:

- **Treatment Purposes:** Murphy Counseling and Therapy Services, LLC may use or disclose your protected information for treatment purposes to doctors, nurses, hospitals, for instance, in order to facilitate your treatment.
- **Payment Purposes:** Your protected information may be used or disclosed to your insurance company, for instance, for payment purposes as it may be necessary to disclose this information so that I may properly receive payment for treatment and services provided.
- **Health Care Operations:** Your protected information may be used or disclosed for health care operations. For example, record review related to quality assurance and improvement activities or third party system related to scheduling/billing operations.
- **Compliance and Quality Assurance:** I may release your protected information to another individual or entity covered by the HIPPA privacy regulations that has a relationship with you for fraud and abuse detection or compliance purposes, quality assessment and improvement activities, or review, evaluation or training of professionals or students.
- **Oversight Activities:** Your protected information may be used or disclosed to an oversight agency for activities authorized by law. Examples of oversight activities include audits, investigations, and inspections. In most cases, the oversight activity will be for the purpose of overseeing services and agency compliance with certain laws and regulations.
- **Judicial and Administrative Proceedings:** If you are involved in a lawsuit or other administrative proceeding, I may release your protected information in response to a court or administrative order. I may also release protected information pursuant to a subpoena or discovery request, but only if efforts have been made by the requestor to provide you with notice of the request and you have failed to object or the objection was resolved in favor of

disclosure, or in the alternative, the requestor has obtained a protective order protecting the requested information.

- **Law Enforcement:** I may release your protected information to law enforcement officials when required or permitted by federal or state law to do so.
- **Emergency Circumstances:** Protected information may be disclosed to personnel who have a need for information about a client, such as for the purpose of treating a medical or mental condition which poses an immediate threat to the health and safety of any individual or the public and which requires immediate intervention.
- **Individuals Involved in Your Care:** I may give out your protected information to a friend or family member who is helping with your care or with payment for your care. However, prior to sharing your protected information in this instance I will first attempt to obtain your verbal or written consent. An example of when obtaining such consent would not be feasible would be if you are involved in a serious accident and unavailable to give your consent and it is necessary for me to speak with your emergency contact or other responsible party.
- **Mandatory Reporting of Child Abuse/Dependent Adult Abuse:** I am a mandatory reporter of child abuse and dependent adult abuse. In the event that there is reason to suspect that child abuse or dependent adult abuse has occurred, your protected information may be disclosed as required by law.
- **As Authorized by Law:** I will disclose your protected information for reasons not described above when required by law to do so.
- **More Stringent Laws:** Some of your protected information may be subject to other laws and regulations and are afforded greater protection than what is outlined in this Notice. For instance, HIV/AIDS, substance abuse, and mental health information is often given more protection. In the event your protected information is afforded greater protection under federal or state law, I will comply with the applicable law.

YOUR RIGHTS

Federal law grants you certain rights with respect to your protected information. Specifically, you have the right to:

- Receive notice of Murphy Counseling and Therapy Services, LLC policies and procedures used to protect your protected information;
- Request that certain uses and disclosures of your protected information be restricted, provided, however, if I release the information without your consent or authorization, I have the right to refuse your request;
- Access to your protected information be amended, although I am not required to grant your request;
- Obtain an accounting of certain disclosures of your protected information for the past six (6) years;
- Revoke any prior authorizations for use or disclosure of protected information, except to the extent that action has already been taken; and
- Request that communications of your protected information are done by alternative means or at alternative locations.

IMPORTANT CONTACT INFORMATION

This notice has been provided to you as a summary of how Murphy Counseling and Therapy Services, LLC will use your protected information and what your rights with respect to your protected information are. If you have any questions or would like more information regarding your protected information, please contact me directly. If you believe your privacy rights have been violated, please speak with me directly about this. You may also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for the filing of a complaint.

This Document to be left with the client

CLIENT RIGHTS AND RESPONSIBILITIES

Clients Have the Right To:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Express and practice religious and spiritual beliefs.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- To request to view their records and to request that the record be amended or corrected if it is determined appropriate by the provider.
- Obtain a second opinion when appropriate.
- A clear working contract in which business items, such as times of sessions, payment plans/fees, absences, access, emergency procedures, and third-party reimbursement procedures are discussed.
- Know about their treatment choices, regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive a clear explanation of their condition and treatment options.
- Give input on the Members' Rights and Responsibilities policy.
- To speak to the provider about a grievance without retaliation.
- To be informed and given the opportunity to complete a written consent prior to being recorded, photographed, or filed.
- Know of their rights and responsibilities in the treatment process.
- Have provider decisions about their care made on the basis of treatment needs.
- Receive information about Provider's qualifications.
- Ask their provider about their work history and training.
- Decline participation or withdraw from services at any time.

Clients Have the Responsibility To:

- Treat the provider with dignity and respect.
- Give the provider information that they need so the provider can deliver quality care.
- Ask questions about care. This is to help understand the services.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let their provider know if they decide to withdraw from the program.
- Make agreed upon payments in a timely manner, if applicable.

This Document to be left with the client