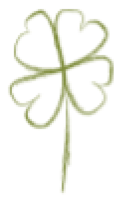

Murphy Counseling LLC
Individual, Marital and Family Therapy
Trauma Counseling
(860) 580 6160
EmilyMurphyLMFT@gmail.com

Office Policies and Philosophy of Treatment

Welcome! I appreciate you giving me the opportunity to help you. This notice is a summary of **office practices** and **procedures** and my personal philosophy of treatment. Kindly read it over, jot down any questions you might have, and **sign at the bottom** that you have read and understand it.

The therapeutic process is one of growth and change, and as such, requires a commitment and investment by client and therapist. Growth and change can be uncomfortable at times, and during this process you might encounter painful emotions and memories. This can lead to some feelings of vulnerability and anxiousness. Exploring the difficult parts of your past and working through those experiences can bring resolution and improved functioning in daily life. **I will consistently request and value your feedback on our work together as we continue the course of treatment in order to ensure that therapy is being helpful to you.**

It is important to remember that this process is *voluntary*, and as such you may withdraw from therapy at any time. However, **if you decide to discontinue, I request a final termination session** to review goals, explore progress, and potentially make referrals for additional resources. In addition, I maintain the right to terminate our session and/or treatment at any point, including continual missed sessions, clients arriving under the influence of drugs or alcohol, violence, or threatening or harassing behavior. I maintain the right to refuse or terminate services if I feel I am unable to meet your needs, in which case you will receive referral to another clinician.

In agreeing to enter into this therapeutic relationship, we agree to respect one another's time. **If you are unable to keep an appointment, please give me as much notice as possible**, and I will make every effort to do the same. Sessions missed without 24 hour notice will be billed, unless in the case of personal or family emergency. As an outpatient practice, I am not "on call," and therefore can't guarantee to be available immediately outside of our regularly scheduled sessions. I will return phone calls within 24-48 hours. **In the event of an emergency, please dial 911 or 211.**

Confidentiality & Privacy

Federal and state laws protect your right to confidentiality with regard to your treatment in my office. Without your permission, I cannot discuss any information you share with me with another person or agency. However, I am mandated by the law to report any information as it pertains to:

- You or your child reporting intention to harm yourself or others
- Reports of actual or suspected abuse of a child, elderly or physically person

In addition, I may be required to provide records or information by court order, and I reserve the right to provide your information to a billing officer to secure payment for services rendered.

Because my office is in a small community, if we see each other outside of treatment, I will not approach you unless you let me know that is acceptable.

Fees & Insurance

My fee is **$150** for an initial diagnostic assessment (typically lasting one hour) and **$100** per session for subsequent sessions (typically lasting 45-50 minutes). **Currently, I am credentialed with Anthem Blue Cross and Blue Shield, Cigna, and Husky.**
Please note, if you decide to utilize your insurance, ultimately the cost of services rendered is your (and not the insurance company's) responsibility. **Therapy fees may constitute a tax deductible medical expense** and you may request a receipt.
As a licensed marriage and family therapist, my professional services qualify for reimbursement under most plans accepting **out of network providers**.

You may want to contact your insurance company to ask the following questions:

- Do I have mental health insurance benefits?
- Do you accept out of network providers?
- How many sessions per year does my health insurance cover?
- What is the reimbursement rate for therapy sessions with an out of network provider?
- Is there a deductible and has it been met?
- Does mental health treatment require preauthorization or a referral from my primary care doctor?
- Are there any specific forms that are needed to submit for reimbursement by my therapist?

- Is approval and/or a referral required from my primary care doctor?

A sliding scale fee is available for a limited number of clients who do not have, or do not wish to use, mental health benefits through their insurance. A fee agreement will be established in such cases.

Costs Outside of Customary Service Provided

In the event that you request written reports or treatment summaries, or if I am called to testify in court proceedings, my fee per hour is $100, which includes any travel time.

Client Agreement

I, the undersigned, have reviewed and understand the Office Policies and Philosophy of Treatment, Confidentiality and Privacy, and Costs Statements. I consent to counseling treatment for myself/my family with Emily Murphy, LMFT.

______________________	____________________________	_________
Printed Name	Signature	Date

I authorize the use or disclosure of all information necessary, including patient records, to process insurance claims and secure payment. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. Additionally, I authorize payment of medical benefits to Emily Murphy, LMFT – Murphy Counseling, LLC for services performed.

______________________	____________________________	_________
Printed Name	Signature	Date

Intake Questionnaire

Name: ______________________________________ DOB: _____________________
Address: _________________________________Town & Zip: ________________________
Primary phone: ___________________ Email: ____________________________________
Please indicate how you prefer to receive messages:
__ Primary phone ___ Text __Email __Do not leave messages
Occupation: ____
Employer: ____
Marital Status: ____________________ Highest grade level completed: __________

Insurance carrier: ____
ID #: _________________ Group #: _____________________ Plan name: _____________
Policy holder's name (if different from patient): ____________________________________
Policy holder's DOB: ___________ Phone number of policy holder: _________________
Policy holder's employer: ____
Policy holder's address: ____
____

Primary care doctor: ____
Please list any current medications: ____

What is your main reason for this visit? Please include any family members' names and ages that will attend sessions.____
____
____
Did anyone refer you? If so, who?____
Previous counseling: ____
____
Current or previous diagnoses: ____
____
Family history of mental issues:____
____
____

Substance Use History

Please check all substances you have used in the past 5 years:
__Caffeine __Tobacco __Marijuana/THC __ Alcohol __Inhalants
__Cocaine/crack __Opiods __Ecstacy __LSD/hallucinogens
__Prescription pills (specify____)
__Other (specify____)

When was the last time you used primary drug of choice? _________________________
How often do you use? ____

Have you ever felt that you should cut down on your drinking or drug use? __Yes __No

Have people annoyed you by criticizing your drinking or drug use? __Yes __No

Have you ever felt bad or guilty about your drinking or drug use? __Yes __No

Have you ever had to drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover? __Yes __No

Do you gamble? __Yes __No
If yes, has your gambling cause significant financial or relational stress? __Yes __No

Please check any of the following that apply to you or your family:
__Eating issues (binging, purging, over/under eating, weight issues)
__Self harm (cutting, suicidality)
__Abuse (past, recent, present; physical, emotional, sexual, neglect)

Please share anything else that might be relevant to your treatment, or expand on any of the above:____
____
____
____
____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *AAMFT Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations. As a marriage and family therapist licensed in this state and as a member of the American Association of Marriage and Family Therapists, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *AAMFT Code of Ethics* and HIPAA.

Child Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution..

Family Involvement in Care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm. This will be discussed with you and your family members during our family and/or couples sessions.

Health Oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on prior consent), peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

<u>Specialized</u> <u>Government</u> <u>Functions</u>. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

<u>Public</u> <u>Health</u>. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

<u>Public</u> <u>Safety</u>. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

<u>Research</u>. PHI may only be disclosed after a special approval process or with your authorization.

<u>Verbal</u> <u>Permission.</u> I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission. Again, this will be discussed with you and your family members at the time of treatment.

<u>With</u> <u>Authorization</u>. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

<u>YOUR</u> <u>RIGHTS</u> <u>REGARDING</u> <u>YOUR</u> <u>PHI</u> You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. We may prepare a rebuttal to your statement and will provide you with a copy. Please let me know if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with myself or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **<u>We will not retaliate against you for filing a complaint.</u> The effective date of this Notice is May 2014.**