I, Leticia Murphy, utilize a whole-person approach to the counseling process. My approach takes into consideration several areas of your life and your family's life in an effort to assess how you are managing these areas and to provide you with the best possible care. Please complete the following form with as much detail as possible.

Application for Care

Client Name: ____
(Last) (First) (M.I.)

Circle: Male Female Date of Birth _________ SSN# _______________ EAP# ___________

Address ____
City State Zip

Home Phone # ___________Cellular Phone # ______________ Email Address:___________________

Current marital status: ☐ Single ☐ Married ☐ Separated ☐ Remarried ☐ Divorced ☐ Widowed

FAMILY INFORMATION

Spouse (if married) ____

Children at home:
Name Age

____
____
____
____

Children not living in your home:
Name Age

____
____
____
____

Other persons currently living in your home and their relationship to you:

____

Has there ever been any serious illness in your family? ☐ Yes ☐ No. If yes, please describe:

____
____

Are any of your family members currently experiencing special problems? ☐ Yes ☐ No. If yes, please describe:

____
____

Have you experienced any significant loss such as: death of family members, divorce, loss of job, etc?
☐ Yes ☐ No If yes, when did this occur?

____
____

Have you experienced past or current domestic violence? If yes when did this occur?
☐ Yes ☐ No

____

____

Have you experienced past or current sexual abuse and or assault? If yes when did this occur?
☐ Yes ☐ No

____

____

Have you experienced past or current child abuse? If yes when did this occur?
☐ Yes ☐ No

____

____

Is there a family history of the following?

Depression	☐ Yes ☐ No	Who___________________	Self______________________
Anxiety	☐ Yes ☐ No	Who___________________	Self______________________
Substance Abuse	☐ Yes ☐ No	Who___________________	Self______________________
Mental Disorder	☐ Yes ☐ No	Who___________________	Self______________________
Learning Disability	☐ Yes ☐ No	Who___________________	Self______________________

PERSONAL INFORMATION

EDUCATION:

Highest grade/level attained ____

MILITARY SERVICE:

Have you served in the military? ☐ Yes ☐ No If yes, which branch of service________________________

Number of years served:____

OCCUPATION:

Place of employment ___________________________Position _____________________
How long in this position? ____
Are you currently experiencing any work related problems? ☐ Yes ☐ No

SOCIAL:

How long have you lived in Las Vegas/Henderson? ____________________________

How many close friends would you say you have? _____________________________

What are your hobbies/Self care
activities:____

SPIRITUAL:

Religious affiliation: __________________Name of church/synagogue you currently attend: __________

PHYSICAL

How often do you go to the doctor? ____________________

Are you satisfied with the medical care you are receiving? ☐ Yes ☐ No

Date of last physical: ____________________

Please list any chronic/serious illness/accidents and date of onset:

____

____

Current medications:

Name	Dosage	Reason

Are you currently sexually active? ☐ Yes ☐ No. If yes, does this involve high-risk behaviors such as multiple partners, unprotected sex, etc? ____________________

Do you exercise regularly? ☐ Yes ☐ No

How would you describe your eating habits? ____________________

Estimated daily caffeine intake (in oz.) ____________________

Do you smoke cigarettes? ☐ Yes ☐ No. If yes, estimate quantity per day: ____________

At present, I would assess my physical condition as being:
☐ poor ☐ fair ☐ average ☐ good ☐ excellent

Are you currently experiencing any sleeping problems? If yes, please describe what you are experiencing.
☐ Yes ☐ No

____

How many hours of sleep do you average per night?____________________

ADDICTIVE SUBSTANCE AND BEHAVIOR HISTORY:

Do you now or have you in the past gambled? ☐ Yes ☐ No

Do you have concern or have others expressed concerns about your gambling behaviors or patterns?
☐ Yes ☐ No

Have others told you they were concerned about your drug or alcohol use? ☐ Yes ☐ No

Do you feel that it takes more alcohol/drugs, in order for you to get the desired effect?
☐ Yes ☐ No

Have you ever felt guilty about drinking/drugs/gambling? ☐ Yes ☐ No

Have you ever had a drink(s) to help you wake up? ☐ Yes ☐ No

Do you have or had any relational and or legal problems directly due to your drinking/drugs/gambling?
☐ Yes ☐ No

Have you ever stopped drinking/drugs/gambling? ☐ Yes ☐ No

For how long? Longest period of time ____________________

Have you ever ☐ temporarily or ☐ permanently lost your memory due to alcohol or drugs? ☐ Yes ☐ No

Have you ever had a seizure (convulsion) because of withdrawal from alcohol or drugs? ☐ Yes ☐ No

Have you ever hallucinated or had shakes, anxiety, agitation, or craving after stopping alcohol/drugs?
☐ Yes ☐ No

Are you currently hearing voices, hallucinations and or experiencing paranoia? ☐ Yes ☐ No

Are you currently suicidal? ☐ Yes ☐ No Have you ever attempted to commit suicide? ☐ Yes ☐ No

Date of attempt and method:____

Do you currently want to hurt others? ☐ Yes ☐ No

Have you ever misused prescription drugs, added or switched doctors to get a prescription? ☐ Yes ☐ No

ALCOHOL AND DRUG USE TABLE

Rank Favorite	Drugs/Alcohol Use	Amount/ Day	How Often	How Long Used	Age First Used	Last Time/How Much
	Alcohol					
	Downers (tranquilizers)					
	Marijuana					
	Cocaine					
	Crack					
	Speed/Crank					
	Hallucinogen/PCP					
	Narcotic(s)					
	Inhalants/huff					
	Prescribed drugs/other					

COUNSELING/PSYCHOTHERAPY/FAMILY THERAPY:

Have you previously received counseling or some other form of mental health or family therapy?
☐ Yes ☐ No

Are you presently receiving counseling or other form of therapy? ☐ Yes ☐ No.

INSURANCE INFORMATION:

Name of the
Insurance:____

Name of Insurance Holder:__________________________________ Date of Birth of Insurance Holder:________

EMERGENCY CONTACT:

Name of the Person:________________________________ Phone number:___________________________

Informed Consent & Limits of Confidentiality

1. Appointments, cancellations, and changes in scheduled appointments can be made by calling the Leticia Murphy at (702) 275-0473. You may leave a message if you reach my after-hours recording. In an emergency, you may wish to call 911, the Suicide Hotline at 1 877 885-4673, or another community agency.

2. If you are unable to keep your scheduled appointment, please call to cancel **at least 24 hours** in advance to avoid incurring your fee for the missed session. Missed appointment fees are **not billable to your insurance company**; therefore, you will be responsible for a **$75.00** short or no notice cancellation fee. You must pay your fee prior to scheduling your next appointment.

3. Initial intake sessions are billed at $150.00 or the maximum allowed by your insurance company, whichever, is greater; sessions are 45-60 minutes. Marriage, family, and individual sessions are billed at $150.00 or the maximum allowed by your insurance company, whichever, is greater; sessions are 45-60 minutes. Fees are payable at the beginning of each session. If you do not have your fee, your appointment will be rescheduled. Fees may be paid with cash or credit card.

4. I will file insurance claims for services to your primary insurance carrier **only**. Please remember that you are responsible for all deductibles, co-pay, and non-covered service amounts. Although we file insurance claims as a courtesy to our clients, all charges are your responsibility from the date the service is rendered. Please be advised that the law allows the referral of unpaid bills to a collection agency or the utilization of small-claims court procedures should your account be sent to collections, you will be responsible for all collection and service charges. If your insurance company denies coverage, you will be responsible for the entire fee. The therapist may utilize a collection company in order to secure payment or small claims court.

5. Fees for documents (FLMA), letters and or reports will be billed based on a case by case basis, depending on the amount of time involved, for a minimum of $30.00 billed directly to the patient. Your insurance will not pay for this service.

6. Fees for court appearances will have a minimum fee of $250.00 and will be billed at $100.00 an hour. This will be billed directly to the client.

7. Fees for copies of your records will be $.60 per page. Clients need to give adequate advance notice (1-2 weeks) for the preparation of records.

No information about you or your treatment will be divulged to any person outside of counseling without your written consent, with the following exceptions: 1. When required by your EAP Program, Insurance Company, Victims of Crime, and or Victims Witness program to authorize or as a condition of payment; 2. In the event that there is a clear and imminent threat of harm towards yourself or against another person; 3. If there is intent to commit criminal activity or awareness or suspicion of such toward a minor, a person over the age of 60, or a physically/mentally vulnerable person; 4. In the event that you threaten or do harm to myself, my staff, and or my property 5. In the event of a court order requiring the personal testimony of the counselor, under legal consultation, in response to a client's raising the issue of mental health in a lawsuit or when minors have limited rights of confidentiality. 6. In a medical emergency involving you.

Mails, Cell Phones, and Computers: It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people. This can compromise the privacy and confidentiality of such communication. E-mails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, the emails sent by Leticia Murphy are not encrypted. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as e-mail or cell phone.

In couple or family counseling, individual confidentiality is rarely in the best interest of all parties, and by signing below you agree to forgo individual confidentialities that are judged counterproductive to the goals of treatment.

The counselor will not acknowledge you should we meet in public without your acknowledgement first, except as would be appropriate in another non-counseling relationship. Finally, the therapeutic relationship generally precludes simultaneous dual relationships.

At times it may become necessary for me to consult with another professional about your treatment. All counselors are required by professional ethics to keep your information confidential. These case consultations/staffing/supervision sessions are helpful to both you and me in determining that I am providing you with the best possible treatment.

I have read and understand the nature and limits of the counseling. I have elected and voluntarily agree to participate under these conditions.

I authorize the release of any medical information necessary to process my claim.

____
Printed Name of Client

______________________________ ______________
Signature of Client (Parent, if minor) Date

Notice of Privacy Practices

Leticia Murphy, M.A., MFT, LADC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. We are required by law to maintain the privacy of your health information, to follow the terms of this notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as described in this notice. We reserve the right to change our practices and this notice and to make the new notice effective for all medical information we maintain. Upon request, we will provide a revised notice to you.

How We May Use or Disclose Your Health Information

We protect the privacy of your health information. The law permits us to use or disclose your health information for the following purposes:
 Treatment, Payment, and Regular Health Care Operations – Information obtained by us may be used or disclosed to a medical specialist, medical laboratory, or other healthcare provider providing treatment, and to bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request. *As and When Required By Law* – We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensation programs, Food & Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces when requested, or if you become an inmate in a correctional facility.
 Personal Communications – We may contact you to provide appointment reminders by postcard, voicemail messages, e-mail, letters and other information about treatment alternatives or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for your care.
 Disclosures to Our Business Associates – There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.
 Victims of Abuse, Neglect, or Domestic Violence – We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Marketing Communications. We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatment, or providers without authorization.

When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow your state law.

You have the following rights with respect to your health information:

 Access: You have the right to review or get copies of your health information. To inspect or copy your health information, you must complete a **Request to Inspect/Access Medical Records** form and submit the request to the contact information below. We will charge you a reasonable cost based fee for expenses such as copies, mailing, and staff time. You will be able to review or have a copy of your health information within 30 days of the request. By law, we can have one 30-day extension of time for us to give you access or photocopies if we sent you a written notice of the extension. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
 Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, where you have provided an authorization and certain other activities, for the past 7 years. To request an accounting, you must complete a **Request for Accounting of Disclosures** form and submit the request to the contact information below. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost based fee for responding to these additional requests.
 Restrictions: You have the right to request that we place additional restrictions on our use or disclosures of your health information. To make such a request, you must complete a **Restriction of the Use of Patient Information** form and submit the request to the contact information below. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
 Alternative Communications: You may request communications of your health information by alternative means or at alternative locations. To request confidential communication of your health information, you must submit a request in writing. Your request must state how or when you would like to be contacted. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. We will accommodate all reasonable requests.
 Amendment: You have the right to request that we amend your health information that is incorrect or incomplete. To request an amendment, you must complete a **Request for Amendment of Medical Records** form and submit the request to the contact information below. If we agree, we will amend the information within 60 days of the request. By law, we can have one 30-day extension of time to consider for amendment if we sent you a written notice of the extension. We may deny your request under certain circumstances. If you would like to exercise one or more of these rights, contact us at the information listed at the end of this Notice.
Changes to this Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. The revised notice will be posted in our office and a paper copy will be available upon request.
For More Information or To Report a Problem
If you have questions or would like additional information about our privacy practices, please contact the Compliance Officer, **Leticia A. Murphy, at Telephone: (702) 275-0473 Fax: (702) 450-1105; Mailing Address: 199 N. Arroyo Grande #100 Ste. 100, Henderson, NV 89074.**

If you believe your privacy rights have been violated, you may request and file a **Complaint Form** and submit the form to the contact information above, for which there will be no retaliation. If you prefer, you can discuss your complaint in person or by phone. You may also submit a written complaint to the U.S. Department of Health and Human Services.

____

Print Patient Name Patient Signature

____ __________________

Parent/Guardian (if patient is under 18 years of age) Date

As of 1/20/2015

Consent to Treatment for A Minor

I, ____________________________ give my permission for ___________________________
(parent/legal guardian) (child)

to receive counseling from Leticia A. Murphy, a Marriage and Family Therapist and Licensed Alcohol and Drug Counselor.

I agree to abide with the laws of confidentiality and to respect the counselor/client relationship that may develop with my child. I have been informed of the benefits as well as to the possible risks associated with the counseling process. I give my full consent and cooperation to this process. I also agree to hold Leticia Murphy harmless except regarding reasonable and customary care.

____ ________________
PLEASE PRINT Name of Child Date

____ ________________
Signature of Parents/Legal Guardians Date

____ ________________
PLEASE PRINT Name of Parent/Legal Guardians Date

____ ________________
Signature of Counselor Date