INTAKE FORMS

Stephanie Murphy, LMFT, LLC
stephanieannmurphy@icloud.com
Mailing address: Stephanie Murphy, LMFT, LLC, 52 Tuscan Way, Suite 202-257, Saint Augustine Florida 32092

Please complete the following questionnaire. This information will be discussed more thoroughly in sessions and used to determine goals for counseling.

Name _____ Date of Birth _____

Address _____

City, State, Zip _____

Telephone Numbers:

Cell _____ Home _____ Work _____

Can I contact you by phone/text? _____ If so, at which number? _____

Can I contact you by email? _____ If so, email address _____

Are you a Florida resident? _____ Driver's License Number _____

Please email a copy of your driver's license to: stephanieannmurphy@icloud.com (Florida statutes require a recipient of services provided by a Florida licensed therapist to be a resident of Florida.)

Occupation _____ Employer _____

Highest Level of Education _____

How satisfied are you with your job? _____

Briefly describe your reason(s) for seeking help at this time. _____

_____

_____

What do you wish to accomplish through the process of therapy?_____

Marital/Relationship Status (check all that apply)

Married Separated Widowed Divorced Remarried

Single Long-term Relationship Cohabitating Other_____

Current Partner's Name _____

Partner's Occupation _____

Length of Relationship _____

How satisfied are you with this relationship? _____

Do you have any children (biological adopted, foster, step)? If so, please list names and ages.

Do your children currently live with you? Yes No

Have you previously been married? If so, what would you like to share about your prior marriage(s)? _____

Have you ever been in counseling/therapy before? Yes No

If Yes, briefly describe the reason(s), date(s), and length of treatment. _____

Was it a positive experience? Yes No
What was helpful? _____

Have you ever attempted suicide? Yes No

Are you currently having suicidal thoughts? Yes No

Are you presently taking any medication? Yes No

If yes, please describe _____

What do you enjoy doing in your spare time? _____

Are there things that you used to do, or would like to do, but currently don't? _____

How would you describe your spiritual or religious beliefs? _____

Do you welcome a Christian perspective during the course of treatment? Yes No

Is there anything else you think would be important for me to know about you or your family?

Did someone refer you? Yes No If yes, who? _____

Please circle any of the following that presently cause you difficulty.

Assertiveness	Worry	Dating
Parenting	Career Choices	Unhappiness
Energy	Marriage	Confusion
Stress	Concentration	My Past
Anxiety	Shyness	Lack of Self-confidence
Depression	Infertility	Physical Symptoms
Anger Issues	Parents	Addictive Behaviors
Moodiness	Relaxation	Sleep Difficulties
Finances	Friends	Decision Making
Fears	Headaches	Relationships
Premarital	Work	Thoughts
Grief/Loss	Infidelity	Inferiority
Sadness	Divorce	Self-esteem
Guilt	Self-concept	Separation

Other_____

Now put an * by the items that are causing you the MOST difficulty.

FINANCIAL RESPONSIBILITY AGREEMENT

As the financially responsible person for the account, I understand that my video or telephone counseling appointment fees are $145.00 for a 50 minute session and will be paid by credit card at the time of my appointment.

I understand that I will be financially responsible for any charges. I acknowledge that I understand and accept the terms of the services for mental health treatment.

I understand and agree that I am financially responsible for all fees described in this agreement.

Client/Responsible Party _____

Stephanie Murphy, LMFT, LLC
stephanieannmurphy@icoud.com

TREATMENT AGREEMENT

This document is intended to clarify in writing some of the issues we may have already discussed verbally that need to be brought to your attention regarding our professional relationship. I have found it is best to specify the content of our therapy relationship by making a mutual agreement in order for you to receive the service you desire. Be assured that I am aware and respectful of your basic rights as a consumer and that I will respond to your needs in the most highly ethical manner, according to the standards of care for my profession. I remain personally and professionally committed to providing you with the highest quality of service.

Client Rights

As a client of Stephanie Murphy, LMFT, LLC, you have certain rights which are as follows:

1. To participate voluntarily in treatment with your therapist and to terminate at any time without penalty.
2. To understand that treatment is individual for up to 60 minutes conducted by your licensed therapist with no absolute guarantee of your desired results by your therapist.
3. To participate with your therapist in exploring and setting your treatment goals and discussing possible benefits and risks.
4. To have reasonable access to your therapist.
5. To have information available to you regarding your therapist's professional license and credentials as well as access to the ethical guidelines or "Standards of Practice" in Marriage and Family Therapy. Your counselor is licensed under Florida Statute 491 of the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling of the Agency for Health Care Administration in Tallahassee, Florida.
6. To be aware that your therapist works in a private practice, teletherapy, video consultation setting.
7. To have all records and other information concerning your involvement with this office held in strict confidence. Certain exceptions are: If you are in clear or imminent danger to yourself and others, in child or elder abuse or neglect cases, therapist's subpoena or court order, or if there is a medical emergency. (See detailed information in Notice of Privacy Practices.)

STEPHANIE MURPHY, LMFT, LLC
Licensed Marriage & Family Therapist
stephanieannmurphy@icloud.com

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.

The term "medical information" is synonymous with the terms "personal health information" and "protected health information" for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable) whether oral or recorded in any form or medium, that is created or received by a health care provider (me), health plan, or others and relates to the past, present, or future physical or mental health condition of an individual (you); the provision of health care (e.g., mental health) to an individual (you); or the past, present or future payment for the provision of health care to an individual (you).

I am a mental health care provider. More specifically, I am a Licensed Marriage and Family Therapist, licensed by the state of Florida by the Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling. I create and maintain treatment records that contain individually identifiable health information about you. These records are generally referred to as "medical records" or "mental health records," and this notice, among other things, concerns the privacy of those records and the information contained therein.

Uses and Disclosures Without Your Authorization – For Treatment, Payment, or Health Care Operations

Federal privacy rules (regulations) allow health care providers (me) who have a direct treatment relationship with the patient (you) to use or disclose the patient's personal health information, without the patient's written authorization for purposes of treatment, payment, or health care operations.

An example of a use or disclosure for treatment purposes: If I decide to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist me in the diagnosis or treatment of your condition.

Disclosures for treatment purposes are not limited to the minimum necessary standards because physicians and other health care providers need access to the full record and/or full and complete information in order to provide quality care from one health care provider to another.

An example of a use or disclosure for payment purposes: If your health plan requests a copy of your health records, or a portion thereof, in order to determine whether or not payment is warranted under the terms of your policy or contract, I am permitted to use and disclose your personal health information.

An example of a use or disclosure for health care operations purposes: If your health plan decides to audit my practice in order to review my competence and my performance, or to detect possible fraud or abuse, your mental health records may be used or disclosed for those purposes.

Please Note: I, or someone in my practice acting with my authority, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.

Other Uses and Disclosures Without Your Authorization:

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

1. Reporting abuse of children, adults, or disabled persons.
2. Investigations related to a missing child.
3. Internal investigations and audits by the department's divisions, bureaus, and offices.
4. Court orders, warrants, or subpoenas.
5. Law enforcement purposes, administrative investigation, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing.

Individual Rights

You have the right to request your therapist to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care.

You have the right to be assured that your information will be kept confidential. Your health care provider will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where our office may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. Your request may be denied in whole or in part if your protected health information:

* Was not created by this office.
* Is not protected health information.
* Is by law not available for your inspection.

* Is accurate and complete.

If your correction is accepted, our office will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. Our office will respond to your letter in writing. You may also file a complaint in the section titled Complaints.

You have the right to receive a summary of certain disclosures made by this office of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6-year period from the date of request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

Your therapist or therapist's office may mail or call you with health care appointment reminders.

Duties of Your Health Care Provider

Your health care provider is required by law to maintain the privacy of your protected health care information. This Notice of Privacy Practices tells you how your protected health information may be used and how your health care provider keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. Your health care provider has the responsibility to notify you following a breach of your unprotected health information.

As part of your health care provider's legal duties, this Notice of Privacy Practices must be given to you. Your provider is required to follow the terms of the Notice of Privacy Practices currently in effect. New or revised notice of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email or at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

If you believe your privacy health rights have been violated, you may file a complaint with the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the US Department of Health and Human Services at 200 Independence Avenue, S.W./Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

For Further information

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General.

Effective Date

This Notice of Privacy Practices is effective beginning July 1 2013, and shall be in effect until a New Notice of Privacy Practices is approved and posted.

Stephanie Murphy, LMFT, LLC
Licensed Marriage & Family Therapist
stephanieannmurphy@icloud.com

NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

Patient/Client _____Date of Birth _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices of Stephanie Murphy, LMFT, LLC. I understand that if I have any questions regarding the notice of my privacy rights, I can contact Stephanie Murphy, LMFT.

Signature of Patient/Client

_____Patient/client refuses to acknowledge receipt

Therapist Signature

INFORMED CONSENT FOR PSYCHOTHERAPY/LIFE COACHING/CONSULTATION

All Clients Must Give Their Informed Consent Prior to Treatment

Client's Name _____

I hereby acknowledge that I have received information regarding informed consent for psychotherapy. I have had time to study the information and to ask any questions that I want to ask concerning the proposed treatment/services.

_____

Client, Parent, or Legal Guardian's Signature

Therapist's Signature