New Patient Welcome

Welcome. You have taken a courageous first step in improving your psychological health, or perhaps that of your child or an important relationship. We admire anyone who is willing to acknowledge there's a problem and ask for professional help. Many people are unable to do either and their condition rarely improves. Admitting there is a problem and asking for help is the first and necessary step in improving your relationship, mood or behavior. We are pleased that you have chosen the Cognitive Behavior Therapy Center. We are committed to helping you achieve your personal goals, by providing the best in psychological services.

Setting realistic expectations is important in anything you do. You can expect results and you should feel a good connection or rapport with your therapist. However, no two therapists (or patients) are exactly the same. Some patients want a therapist who allows them to freely express their feelings and who provides gentle support. Others want a much more active therapist who identifies problems, gives very specific guidance and pushes them to do their homework. Therapy is a collaborative process. We encourage you to ask questions and provide feedback to your therapist about your concerns, needs or preferences. Please ask to see another therapist if, after 3-5 sessions and a sincere effort, you do not feel there is a good fit or if you are not happy with the results you are getting.

While we all want results, we have to recognize that much is required, of therapists and patients alike, to change habitual ways of thinking and acting. The length of time it takes to effect change varies greatly from one patient to another, depending on the patients' presenting problems and psychological resources. Most problems we treat have a long history and rarely disappear suddenly overnight. Generally slow, steady progress is good.

Most of us have left highly motivating workshops, sermons and therapy sessions with lots of great intentions, only to slip back into old habits. Lasting change requires that one person (in a family or company) be highly committed to change. These people are not always easy to live with. Change is often uncomfortable, because we are revisiting past traumas, identifying negative patterns of thought and behavior, and are trying out new, unfamiliar ways of thinking and acting. No pain, no gain. While we wish it were otherwise, pain is often the prime motivator for change. However, there are major rewards for those willing to do the hard work to make themselves and their relationships healthier and more positive, resilient, calm, thoughtful and nurturing. We are here to help you. Never hesitate to let us know if you have complaints or compliments.

William L. Mulligan PhD

William L. Mulligan, Ph.D.

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HIPAA DISCLOSURE

This notice is written in accordance with the Health Insurance Portability and Accountability Act. It describes how medical information about you may be used and disclosed and how you can get access to this information.

William L. Mulligan Ph.D., PC is committed to the privacy of your personally identifiable health information (PHI) and we observe strict privacy standards to protect it from unauthorized uses or disclosure. As a general rule, therapists and clerical staff will disclose no information obtained from your contacts with them, or the fact that you are their patient, except with your written consent. Upon request for such authorization, you have the right to refuse and/or revoke any disclosure of your personal health or mental health information. However, there are some important exceptions to this confidentiality rule, as described below, or as otherwise specified by law.

PHI may be provided to others without your further consent if: (A) There is a threat of harm to yourself or others, (B) Your provider is on vacation or is otherwise unable to be reached during an emergency and a covering practitioner requires information about your care in order to assist you, (C) It is required to obtain payment for services from your insurance carrier, (D) A release of information already exists, or (E) One of our contracted employees requires information to serve you.

Virginia law requires therapists and psychiatrists to release information to others in the event of: (A) Suspicion of abuse or neglect of a child or of an aged or incapacitated adult, (B) Receiving information that a therapist or physician is engaging in illegal practices, (C) A client is licensed by a Health Regulatory Board and the practitioner believes that the client's condition places the public at risk, or (D) The client has voiced a threat to directly harm someone else.

A Virginia Court case may require that your therapist release PHI in the event of: (A) A criminal case, (B) Child abuse cases, (C) Any court case in which your mental health is an issue, or (D) Any case in which the judge "in the exercise of sound discretion, deems it necessary to the proper administration of justice." This means that information communicated to your therapist can be admitted as evidence in a court case against your wishes if a judge so rules. Others sometimes issue a subpoena seeking either treatment records or testimony from your present or former treatment provider(s) as evidence in a court case.

Virginia law allows certain others to request access to your PHI in specific circumstances. These include: (A) Protective Service Workers to whom your treatment provider has reported suspicion of abuse or neglect, if they so request, (B) Court-Appointed Special Advocates in child abuse or neglect proceedings, if the court so orders, and (C) Evaluators for minors' involuntary commitment to inpatient treatment, if they so request.

If you are under 18, Virginia law allows your parents to obtain information and/or records related to your treatment. *(Continued on next page)*

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If you wish your therapist to obtain third party reimbursement for services, certain information must be provided. You must decide whether to give consent for your therapist to release the necessary information to an insurance company (or other third-party payer) in order to receive reimbursement. This usually involves providing information about dates of treatment, type of treatment, and nature of your problem (diagnosis).

When an insurance company contracts with a company to administer the mental health portion of a patient's health care benefits, this is called Managed Care. Many managed care companies require that you obtain a referral from your primary care physician and/or pre-authorization from a case manager in order to receive services. Most managed care companies initially authorize a limited number of sessions, and then require that your therapist furnish a written report pertaining to your presenting issues, your diagnosis, a brief description of your current situation, history of previous treatments, and goals for your therapy. If additional sessions are authorized, updated Treatment Plans about your progress may be required throughout your treatment.

As a consumer of mental health services, you need to know that the information provided to any third party payer becomes a permanent part of your file with them, and that neither you nor your treatment provider will have control over the future confidentiality of that information, including whether it is made available to an insurance data bank and/or your employer, or is re-released for other purposes.

You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, your treatment provider may not be required to agree to a restriction that you request. You have the right to receive Protected Health Information by alternative means and at alternative locations (e.g., having your bills mailed to a different address). You have the right to inspect or obtain a copy (or both) of your Protected Health Information and psychotherapy notes from your treatment provider's notes and billing records that are used to make decisions about you for as long as this information is maintained in the record (no more than 7 years for adults and ten years for minors). Your treatment provider may deny you access to your PHI under certain circumstances but in some cases you can have this decision reviewed. You have the right to request an amendment of your PHI for as long as the information is maintained in the record. Your treatment provider may deny your request. You have the right to request an accounting of the disclosure of your Protected Health Information for which you have neither provided consent or authorization.

If you are concerned that your privacy rights have been violated or you disagree with a decision made by your treatment provider about access to your records or for additional information regarding privacy policy please contact our Privacy Officer, William Mulligan, Ph.D., at 1403 Greenbrier Parkway, Suite 215, Chesapeake, VA 23320 or the Secretary of the U.S. Department of Health and Human Services.

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Patient Information

Date:_____
Patient Name: Last_____ First_____ MI___
Male___Female_____ Single_____ Married_____
Address:_____ City:_____ ST.___ Zip:_____
Phone: Home (___)-_____ Cell (___)-_____ Work (___)-_____
Email:_____
Patient's Social Security Number:_____ Date of Birth:_____
Employer:_____
Address:_____ City:_____ ST.___ Zip:_____
Emergency Contact: Name:_____ Phone: (___)-_____
Responsible Party (If Minor): _____ Relationship:_____
Address:_____ City: _____ ST.___ Zip:_____
Phone: (___)-_____
Referral Source:_____ Are you currently seeing another therapist? ___
If yes, who? _____

INSURANCE INFORMATION
Subscriber Information
Primary Insurance Company: _____ ID: _____
Subscriber/s Name: _____ SS#: _____
Date of Birth: _____ Insurance Phone Number: (___)-_____
SECONDARY INSURANCE
Secondary Insurance Company: _____ ID: _____
Subscriber/s Name: _____ SS#: _____
Date of Birth: _____ Insurance Phone Number: (___)-_____

AUTHORIZATION FOR TREATMENT
I hereby authorize treatment for the above patient by William L. Mulligan, Ph.D., PC, T/A Cognitive Behavior Therapy Center and professional staff. I also authorize release of my records to (1) any employee, if necessary to provide these psychological services to me or to bill for said services and (2) any agency involved in the payment for services rendered to this patient. I assign all benefits for said services to William L. Mulligan, Ph.D., PC. Finally, I the undersigned agree to pay the amount due, and if not paid at the time services are rendered, I shall be responsible for all costs of collection, including court costs and attorney fees of 33.33%.

Signature_____ Date_____
(Signature of Patient or Responsible Party if patient is a minor)

Witness _____ Date_____

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Financial Agreement

Co-payments, deductibles and/or payment for any service not covered by your insurance carrier must be paid to WLM, Ph.D., PC at the time of each visit. We accept cash, personal checks and credit cards. A charge of $35.00 will be made for any returned checks. Insurance is filed free of charge only once as a courtesy to you, upon receipt of your signature below. This is not a guarantee of benefits and it is your responsibility to verify coverage. **Your insurance carrier has a contract with you,** not the provider named above. **Although we file claims for your convenience, you are ultimately responsible for all charges covered or not covered.** If your insurance carrier has not paid within 30 days of the date of service, you will be required to pay any remaining balance. If your carrier pays at a later date, you will be reimbursed for any overpayment. _____

You are responsible for providing accurate information regarding your insurance carrier/policy. You are further responsible for notifying us of any changes with your insurance carrier that may occur after you begin therapy. William L. Mulligan Ph.D., PC follows the HIPAA guidelines for filing and maintaining Protected Health Information. I have been given a copy of these HIPAA guidelines. _____

To file for insurance reimbursement for our services, it may be necessary to provide your insurance carrier with certain personal health information, such as dates of treatment, type of treatment, presenting symptoms and your diagnosis. By authorizing us to file for insurance reimbursement, you are giving us your permission to release such personal health information._____

Account balances over 30 days will accrue interest at the rate of 1.5% per month (18% APR) of the outstanding balance. Failure to comply with the terms of this financial agreement will result in collection procedures. In the event a delinquent account is referred to an attorney to collect any amounts due or to enforce this agreement, you will be responsible for additional collection costs including court costs and attorney's fees of 33.3%. _____

I acknowledge that I have read and fully understand the terms of this agreement.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Print name of Patient or Responsible Party Date

_____ _____
Witness Signature Date

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Court-Related Fees Agreement

This document represents a binding contract between the parties signed below, who have each agreed to participate in individual, marital or family therapy with the other parties. Each party hereby acknowledges that the goal of psychotherapy is the amelioration of psychological distress and interpersonal conflict, and that success in psychotherapy requires honesty and openness during the therapy sessions.

Therefore it is agreed by all parties that they will not subpoena the testimony or treatment records of any professional employee of William L. Mulligan, Ph.D., PC, T/A Cognitive Behavior Therapy Center, hereinafter, collectively referred to as professional(s), for a deposition or court hearing of any kind, for any reason.

Furthermore, should any Professional(s) be required to testify in a deposition or court proceeding, or produce treatment records, the undersigned party, who has initiated this action (or who's attorney has initiated actions requiring said Professional(s) to testify or produce therapy documents), agrees to pay court testimony fees of $350.00 per hour for each hour required by each Professional, to produce documents, appear at depositions, participate in phone conferences with other professionals, time in court, preparation time, travel time, and any other related expenses. Each Spouse agrees to pay his or her 50% share of any fees incurred for phone conferences & depositions (including preparation time) required by (1) Guardian Ad Litems or (2) Independent Parental Capacity evaluators.

Given that each Professional will have to cancel at minimum 6 hours of therapy appointments for a deposition or court testimony and will need several hours to make necessary preparations, the retainer/minimum fee for any court-related testimony will be $3500.00 for each Professional. The minimum retainer for a phone conference with a GAL will be $350.00. Retainers must be paid 2 weeks in advance of any scheduled court hearing, deposition or GAL conference.

The therapy participants hereby agree to all of the foregoing, as witnessed by their signatures below.

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____

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Appointment Scheduling & Late Cancellation Notice

We have prepared this memo in an effort to minimize scheduling errors and inconvenience for patients and therapists alike. Please review the following points carefully and bring any questions you may have to your therapist's attention.

- Please make sure we have your email and a primary phone number. We provide an automated appointment reminder service that will send you emails, text messages and phone calls, requesting that you reply with a ***"confirm"*** or ***"reschedule".*** When you reply, additional reminders for that appointment will stop. This automated service is provided as a courtesy. It is your responsibility to remember which appointments you schedule and which appointments you cancel.

- Please ask for an appointment card and keep these as proof in the event of an error on our part in scheduling. We encourage you to also enter your appointments into your calendar.

- If you would like to reserve the same day and time each week, you may schedule a maximum of four appointments in advance. If you make several appointments at one time and then cancel one, we will assume you intend to keep the other future appointments, if you do not notify us to cancel them as well.

- If you cannot keep an appointment, please give us a **minimum of 24 hours advance notice** (preferably more if possible). We understand that patients have legitimate reasons for cancelling and may not be able to give 24 hours advance notice. At the same time, your therapist may have a waiting list of patients who want to be seen and a cancelled appointment cannot be filled without adequate notice. ***Therefore, it is our practice's policy to charge a nominal $50.00 late fee, if you cancel or miss an appointment, with less than 24 hours notice, regardless of the reason.*** This fee will increase for each additional late cancellation ($75, $100, $125) and staff are unable to waive these fees. ***You can avoid a LC charge if there is an ongoing reason why you may have to cancel with less than 24 hours advance notice (e.g. health, job or sick child), by waiting to call on a morning when you are free, to see if your therapist has an opening for that day.*** While your therapist may not have an opening on a given day, we can usually accommodate you sometime during the week, since we do get last minute cancellations.

- ***LC & MA fees must be paid before your next appointment.*** We will attempt to call you, but if the payment is not made, we may have to cancel future appointments that have been scheduled.

- Finally, it is important that you arrive on time, in order to receive the full 55 minutes that has been reserved for your appointment. If you arrive more than 15 minutes late, we may have to cancel and reschedule your appointment, because we will not be able to give you all of the time allotted to you. If we have to cancel your appointment because you are late, there will be a LC charge. ***Thank you for your understanding and cooperation!***

Signature _____ ***Date*** _____

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CBT Center Pre-evaluation Questionnaire (Child & Adolescent)

Please complete this form and bring it to your *first* visit to expedite the evaluation process

Name of Person Completing Form:_____ Today's Date: _____

Child's Name: _____ Child's Age: _____ Child's DOB: _____

Child's Race: _____ School: _____ Grade: _____

Immediate Family Member	Relationship	Age	Live with Child?

Please describe the *main* issue that led you to seek treatment:

_____

_____

What specific goals would you like to achieve by being seen here?

_____

_____

MEDICAL / TREATMENT HISTORY

1. History of Psychological/Psychiatric Treatment
   a. Has your child ever received any outpatient treatment or evaluations for any emotional, behavioral, substance abuse, or personal difficulties? ☐ Yes ☐ No

      Date Clinic Name of Provider Reason

      _____

      _____

   b. Has your child ever been hospitalized for anxiety, depression, substance use, or any other emotional or behavioral problem? ☐ Yes ☐ No

      Date Hospital Reason

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c. Is your child *currently* taking any medications for anxiety, depression, or any other emotional problem (include sleep medication)? ☐ Yes ☐ No

Date Clinic Doctor Reason Medication/Dose

d. Has your child *previously* taken any medications for anxiety, depression, or any other emotional problem (include sleep medication)? ☐ Yes ☐ No

Date Clinic Doctor Reason Medication/Dose

e. If *current* or *past* history of psychotropic medication use:
Have you ever experienced problems with these medications such as side effects, withdrawal problems, etc.? ☐ Yes ☐ No

If *yes,* specify: _____

2. Medical History
   a. Child's Height? _____ a. Child's Weight? _____
   b. Is your child currently being treated for any physical disease or condition? ☐ Yes ☐ No

   If *yes,* specify: _____

   c. Has your child ever had to be hospitalized for a physical problem? ☐ Yes ☐ No

   Date Reason

   d. Has your child ever had a surgical procedure? ☐ Yes ☐ No

   Date Reason

   e. Has your child ever had a concussion or any head injury? ☐ Yes ☐ No

   Date Reason Loss of consciousness?

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f. Does your child have any allergies? ☐ Yes ☐ No

If *yes,* specify: _____

FAMILY HISTORY: FATHER

Age: _____ Occupation: _____

Highest grade completed: _____

Learning or Behavior problems (specify): _____

Medical problems (specify): _____

Has the child's father or any of his first degree (parent, sibling, child) blood relatives ever had problems similar to those your child has or other psychiatric/psychological conditions? If so, describe (who, what): _____

FAMILY HISTORY: MOTHER

Age: _____ Occupation: _____

Highest grade completed: _____

Learning or Behavior problems (specify): _____

Medical problems (specify): _____

Has the child's mother or any of her first degree (parent, sibling, child) blood relatives ever had problems similar to those your child has or other psychiatric/psychological conditions? If so, describe (who, what): _____

PREGNANCY: (This information pertains to the mother of the child being seen)

Were there any complications during pregnancy? If so, specify: _____

Smoking during pregnancy? ☐ Yes ☐ No

If yes, average number of cigarettes per day: _____

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Alcoholic consumption during pregnancy? ☐ Yes ☐ No

Describe, if any beyond an occasional drink: _____

X-ray studies during pregnancy: _____

Duration: _____ weeks

DELIVERY AND POST DELIVERY:

Delivery on time? ☐ Yes ☐ Early (How early?): _____ ☐ Late (How late?): _____

Type of labor: ☐ Spontaneous ☐ Induced

Forceps: ☐ Yes ☐ No

Type of delivery: ☐ Normal ☐ Breech ☐ Cesarean

Birth Weight: _____ Pounds _____Ounces

Total number of days baby was in hospital after delivery: _____

Describe any complications during delivery (cord around neck, injuries, etc.) or post delivery (jaundice, incubator care, birth defects, respiration, etc.): _____

_____

INFANCY-TODDLER PERIOD: (If any of the following were present to a significant degree during the first few years of life, please check yes and describe briefly.)

a. Did not enjoy cuddling ☐ Yes ☐ No
   Describe: _____
b. Was not calmed by being held and/or stroked ☐ Yes ☐ No
   Describe: _____
c. Colic ☐ Yes ☐ No
   Describe: _____
d. Excessive Restlessness ☐ Yes ☐ No
   Describe: _____
e. Diminished sleep due to restlessness/easy arousal ☐ Yes ☐ No
   Describe: _____
f. Frequent head-banging ☐ Yes ☐ No
   Describe: _____
g. Constantly into everything ☐ Yes ☐ No
   Describe: _____

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h. Excessive number of accidents compared to other children ☐ Yes ☐ No

Describe: _____

i. Excessive fears compared to other children ☐ Yes ☐ No

Describe: _____

DEVELOPMENTAL MILESTONES

Milestone	*Age*	*Early*	*Normal*	*Late*	*?*
Walked without assistance					
Spoke first words (besides ma-ma and da-da)					
Said phrases					
Potty trained (day)					
Potty trained (night)					
Said alphabet in order					
Rode bicycle (without training wheels)					
Buttoned clothing					
Tied shoelaces					
Named colors					
Began to read					

Comments? _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his/her age? ☐ Yes ☐ No

If *no,* why? _____

How would you rate your child's overall level of intelligence compared to other children?

☐ Below Average ☐ Average ☐ Above Average

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SCHOOL

Rate your child's school experience related to:

	Academic Learning			***Peer/Social Experience***		
	Good	*Average*	*Poor*	*Good*	*Average*	*Poor*
Nursery School						
Kindergarten						
Elementary School						
Middle/Junior High						
High School						

Has your child ever had to repeat a grade? ☐ Yes ☐ No

If so, when? _____

Present class placement: ☐ Regular class ☐ Special class (specify): _____

Kinds of special therapy or remedial work your child is currently receving: _____

_____

Briefly describe any academic problems: _____

_____

Briefly describe any behavioral problems at school: _____

_____

PEER RELATIONSHIPS

Does your child seek friendships with others Yes___ No___

Is your child sought by peers for friendship? Yes___ No___

Does your child play mostly with children his/her own age? Yes ___ No ___

If no, are playmates: Older_____ Younger _____

Briefly describe any problems your child may have with peers: _____

_____

HOME BEHAVIOR

To some degree, all children exhibit some degree of behavioral problems. Please describe those which you believe your child exhibits to an excessive degree when compared to other children his/her age or those you believe to be problematic: _____

_____

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SYMPTOM CHECK LIST

At one time or another, most children exhibit one or more of the symptoms listed below. Please check if your child has exhibited any of these symptoms in the past or exhibits currently. Mark only those symptoms which have been to a significant degree over a period of time. Check only problems which you suspect are unusual when compared to other children of the same age.

Symptom	***Past***	***Now***	***Comments***
Behavior			
Acts Immature			
Frequent temper tantrums			
Aggressive (physical or verbal)			
Hyper, unable to sit still			
Procrastinates			
Excessive silliness or clowning			
Inappropriate sexual behavior			
Enuresis (wetting)			
Destruction of property			
Excessive demands for attention			
Works too hard			
Suspicious, distrustful			
Suicidal or self-injurious behavior			
Poor motivation			
Brags or boasts			
Perfectionism			
Encopresis (soiling)			
Refuses to try new things			
Back talks, disrespectful			
Oppositional, defiant, disruptive at home			
Cruelty towards animals			
Stealing			
Frequent use of profanity			

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Symptom	***Past***	***Now***	***Comments***
Argumentative			
Persistent lying or cheating			
Extreme response if doesn't get his/her way			
Sore loser			
Criminal/dangerous acts			
Substance use			
Runs away from home			
Sneaks out			
Stays out past curfew			
Oppositional, defiant			
Selfish			
Violent outbursts of rage			
Lacks guilt or remorse			
Disrespectful			
Always complaining			
Bullying or teasing			
Very stubborn			
Annoys others on purpose			
Nervous mannerisms, tics, twitches			
Involuntary grunts or vocalizations			
Repetitive/compulsive behaviors			
Poor attention/concentration			
Irresponsible			
Disorganized			
Strange ideas			
Feels others are persecuting him/her			
Excessively competitive			
Excessive self/criticism			
Extremely forgetful			

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Symptom	*Past*	*Now*	*Comments*
Loses things frequently			
Excessive fidgeting			
Hair pulling, nail biting, skin picking			
Head banging			
Speaks rapidly and under pressure			
Talks too much			
Impulsive			
Excessively irritable			
Blames others for mistakes or behavior			
Poor tolerance of criticism			
Stuttering			
Excessive desire to please others			
Incomprehensible speech			
Passive and easily led			
Little concern for hygiene			
Refuses to speak			
Unwanted thoughts, upsetting images			
Sees or hears things others don't			
Appears to be in own world			
Staring spells			
Low energy			
Excessively critical, cynical, negative			
Fixation or preoccupation			
Difficulty making decisions			
Sensitivity to noise, light, tactile/textures			
Eating			
Eats non-edible substances			
Eats too much or too little			
Restricted variety of foods			

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Symptom	*Past*	*Now*	*Comments*
Emotions			
Excessive fears (specify)			
Frequent worrying (specify)			
Negative self-esteem			
Negative body image			
Severe mood swings			
Elated mood, Euphoria			
Depression, sadness			
Loss of interest, bored			
Thoughts of suicide, death, dying			
Cries frequently and easily			
Overly sensitive			
Excessive guilt			
Flat emotional tone			
Pouts/sulks			
Medical/Somatic/Sensory			
Frequent headaches			
Frequent stomachaches			
Other aches and pains			
Other medical/physical problems			
Sleep			
Walking or talking in sleep			
Nightmares			
Night terrors			
Insomnia or other sleep difficulties			
Social			
Shy, withdrawn			
Few, if any, friends			
Poor eye contact			

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Symptom	***Past***	***Now***	***Comments***
Communication difficulties			
Socially awkward			
Aloof			
Academic			
Truancy from school			
Poor grades			
Fails to complete assignments			
Disruptive in school			
Defiant			
Excessive detentions			
Suspensions or Expulsion			
Test anxiety			

ADDITONAL REMARKS: _____

_____

_____

Thank you

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