MICHAEL MURPHY, L.C.S.W.
205 Powell Place
Brentwood, TN 37027

Client Name: _____ Gender: _____ Date of Birth: _____

Social Security #: _____ Marital Status _____

Home Address: _____

_____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Employer: _____ Occupation: _____

Work Address: _____

Person Responsible for Payment: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Address (if different) _____

Home Phone: _____ Work Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Referred by: _____

Primary Care Physician: _____ Phone: _____

Address: _____

**→ To file insurance, I must have the following information:**

Primary Insurance:

Insurance Company Name: _____ Phone: _____

Name of Insured: _____ Employer: _____

Social Security #: _____ Date if Birth: _____

Policy #: _____ Group #: _____ Eff. Date: _____

***PLEASE READ & COMPLETE THE NEXT SHEET –***

## PAYMENT/INSURANCE AGREEMENT & AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

AGREEMENT TO PAY. I agree to pay fees/co-payments for service at the time of each visit. I understand that I am personally responsible for payment of all charges. If the patient has coverage under a managed health plan (HMC), PPO, etc.) to which I subscribe, and in which the therapist is a participating provider, I am responsible for the co-payment as determined by the insurance plan. I understand that the therapist will file insurance as a courtesy, however, this does not release me of my responsibility for payment of the charges for services. I am responsible for payment even if a divorce settlement dictates that medical bills are to be paid by a former spouse. Appropriate documentation will be provided with which reimbursement may be sought from the ex-spouse. I understand that delinquent balances are subject to collection procedures, and I am responsible for any collection agency or court fees. If the therapist must utilize a collection agency to collect on a delinquent account, such action could require that the therapist release to the collection agency, attorneys and/or the court information including, but not limited to, the identities of the parties involved, the dates and nature of the charges, and any other information contained on any claim filed.

FEE SCHEDULE. The usual and customary fee for psychotherapy is $160.00 for initial intake and $135 per clinical hour. In addition to weekly appointments, there may be a charge for other services such as report writing, telephone conversations, which last longer than 15 minutes, requested attendance at meetings/consultations with other professionals, or preparation of treatment summaries. These are charged on a prorated basis. Some of these costs are not covered by insurance.

MISSED APPOINTMENTS. I understand that once I have made an appointment, the time is reserved just for me. Therefore, I understand and agree that I may be charged for and required to pay for missed appointments not cancelled 24 hours in advance. **Insurance does not reimburse for broken appointments**, and I will be responsible for this fee.

LEGAL SERVICES. If I am here for that purpose, I will discuss this with the doctor ahead of time and discuss fees for such services. Insurance also does not typically cover services performed for legal purposes, such as custody evaluation, etc. I understand that I will be expected to pay for professional time required, even if the therapist is compelled to testify by another party. If I am here as a result of a court order, I understand that this is an agreement between me and the courts, not the therapist, and I am responsible for payment of all charges. Because of the complexity and difficulty of legal involvement, the fee is $250.00/hour for preparation for and attendance at any legal proceeding.

INSURANCE REIMBURSEMENT. I understand that I am responsible for knowing exactly what mental health services my insurance plan covers and securing any pre-certification that my insurance may require for reimbursement. Payment for any charges denied or not covered by my insurance company becomes my responsibility, and I agree to pay these charges. "Managed Health Car Plans," such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. I understand that securing benefits under health insurance or other health plans will require that the therapist provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the therapist to provide the plan management with additional information concerning case history. , presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the patient. I also understand that I have the right to pay for services myself and avoid the complexities of filing insurance altogether. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Insurance to be filed by: Michael Murphy, L.C.S.W. or Client or Neither

**By signing below, I authorize [provider name, credentials] to file insurance claims and to pay [provider name, credentials] directly. I authorize payment of medical benefits to [provider name, credentials] by my insurance company.**

_____ _____

Signature of patient, parent or legal guardian Date

**By signing below I acknowledge that I have read and understand the above information.**

_____

Signature of patient, parent or legal guardian

## PSYCHO/SOCIAL/MEDICAL INFORMATION

Date: _____ Name: _____ Age: _____

Purpose of Visit: _____

Marital Status: (circle one) M S W D

Number of Times Married: _____ Lengths of Marriages: _____

Number of Children: _____ Ages: _____

Number of Stepchildren: _____ Ages: _____

| **Persons Living in Household** | **Relationship** | **Age** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Children Living Outside of the Household: _____

Current School/Employment: _____

What do you like about your work? _____

Number of jobs in the Past 5 Years: _____

Years of Education Completed: _____

Religion (optional): _____

Past or Present Legal Problems: _____ If yes, describe: _____

_____

Have you ever been hospitalized for any psychiatric or chemical dependency issues?

Yes _____ No: _____ If yes, give dates and name(s) of facility(ies) and the general outcome of treatment: _____

_____

_____

**Previous Outpatient Therapy:**

| Therapist(s) | Approximate Dates | Location | Was it Helpful? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Primary Care Physician:**

_____

_____

**Specialists you see:** _____

_____

_____

Please list all current medications, dosages and the prescribing physician:

_____

Medications within the past year: _____

Do you drink alcohol? Yes / No How often? _____ How much?_____

Age of first drink:_____Do you use drugs recreationally? _____

If so, which ones: _____

Do you think you have a problem with drugs or alcohol? _____

Have you ever had problems at work or in relationships because of substance abuse? _____

If so, please describe: _____

Do others think you have a problem with alcohol or other drugs?

What are the past or present circumstances relevant to your decision to come to therapy at this time?

What do you like best about yourself?

When you make the changes or decisions that you want to make, how will you and your life be different from now?

Have you ever attempted suicide? _____

If yes, please explain when, circumstances and method:

Have you had suicidal thoughts or plans within the past year? _____

If yes, please note when, circumstances and method planned:

Are you currently having suicidal thoughts or plans? _____

Have you ever had problems with anger, rage or aggressive behavior? _____

If yes, please describe history:

Have you ever had – or are you currently experiencing – urges or plans to hurt or kill someone? _____

If yes, please explain:

Please list significant emotional or medical problems of family / close friends:

Please list current and p ast significant physical illnesses, surgeries and hospitalizations (with approximate dates):

**Please *circle* any conditions listed below that you have had or are currently experiencing:**

| Description | Approximate date(s) of onset | Experiencing now? |
|---|---|---|
| Anxiety episodes/symptoms | | |
| Phobias | | |
| Loss of appetite | | |
| Increase of appetite | | |
| Loss of interest in activities | | |
| Fatigue/loss of energy | | |
| Feelings of hopelessness | | |
| Insomnia | | |
| Excessive sleeping | | |
| Obsessive (repetitive or hypervigilant) thinking or behavior | | |
| Anorexia | | |
| Compulsive eating/bulimia | | |
| Body Image Distortion | | |
| Compulsive drinking | | |
| Compulsive drug use | | |
| Compulsive spending | | |
| Compulsive sexual activity of some kind | | |
| Smoking cigarettes | | |
| Compulsive working | | |
| Victim of sexual abuse | | |
| Sexual abuse of someone by you | | |
| Victim of physical abuse | | |
| Physical abuse of someone by you | | |
| Loss of memory/missing time | | |
| Hearing voices | | |
| Seeing visions | | |
| Bereavement | | |

## PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data (Transaction Rules), the keeping and use of patient records (Privacy Rules), and storage and access to health care records (Security Rules). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients with a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Michael Murphy, L.C.S.W.
Licensed Clinical Social Worker
Psychotherapy Practice

I, _____ understand and have been provided a copy of Ms. Murphy's "Patient Notification of Privacy Rights" which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document before signing this acknowledgment form.

_____ _____

Patient Signature (or parent of minor or legal charge) Date

If legal charge, describe representative authority: _____

# POLICY & PROCEDURES – HIPAA COMPLIANCE
## MICHAEL MURPHY, L.C.S.W.

My policy and procures for HIPAA compliance are contained in my Patient Notification of Privacy Rights statement, my customary administrative paperwork and consent-to-care forms, my specialized designated mental health record set forms, and the other administrative forms attached with this document. All of my privacy policies and procedures are embedded in these documents. Additionally, I provide this policy and procedures document to reaffirm the privacy operations of my practice.

### 1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

A. While I am permitted by HIPAA to use PHI for treatment, payment and healthcare operations, I only do so with a consent-to-care form signed by the patient.

B. I do not treat minors without parental consent.

C. For disclosure of patient information outside "TPQ" purposes, I first secure the specified authorization in writing, using my authorization PHI forms.

D. In the event that psychotherapy notes are ever shared, I first secure another specified authorization form, after providing the patient informed consent on these matters.

E. All the authorization forms in my practice comply with HIPAA regulations.

### 2. USE AND DISCLOSURE OF PHI – MINIMUM AND NECESSARY DISCLOSURES

In my practice, I am the SOLE provider who has access to the complete protected mental health record of my patients. I purposefully separate out administrative information and clinical information in my patient charts.

I always disclose and use only the minimum and necessary information needed for the requested task. For example, I do not release my psychotherapy notes to insurance carriers for utilization review. It is not necessary to do so, and I inform my patients of this right. I am always mindful of how documentation necessarily compromises the privileges of my conversations with my patients. I am the only person in my practice who sends records, so I can easily differentiate progress notes from Psychotherapy notes. No one but me has access to my private clinical records, which I keep under lock and key. If I ever receive an authorization that seems "above and beyond what is minimum and necessary," I first call the patient to inform them of their rights and then modify any authorization so that it is consistent with the minimum and necessary requirement.

### 3. NON-AUTHORIZED DISCLOSURES

Non-authorized disclosures are made in accordance with state and federal law and my patients are notified of these occurrences as specified in my Patient Notification of Privacy Rights statement.

## 4. Patient Notification of Privacy Rights Statement

I give my patients their Notification of Privacy Rights at the beginning of their care and secure their signature to indicate recipient of this document. My document clearly outlines their various rights including, but not limited to, the right to inspect, copy and amend records, confidential handling of materials, restrictions of disclosures and other matters reviewed in those documents. Copies of all the forms I use to enact these administrative operations are attached, which clearly outline the procedures I follow to protect the privacy rights of my patients.

## 5. Business Associates

I have a contract with Misty Campbell, PROPER Billing Services, who provides my billing and insurance services. My contract with her helps augment privacy practices for my patients. I provide the training for these Business Associates on these important privacy matters.

## 6. Privacy Officer and Complaints

I serve as the Privacy Officer for my practice. Patients are encouraged to talk to me about any real or perceived compromises of their privacy rights. I have also told them they can contact the Department of Human Services, Office of Civil Rights, Washington, D.C., if they prefer to file a complaint at that office rather than talking with me directly about these matters. I review any complaint in detail and strive to arrive at a resolution satisfactory to the patient. In the event I am uncertain as to how to proceed, I seek consultation from other informed colleagues on this subject, or the legal staff of the National Association of Social Workers.

I keep abreast of developments in the field and implement changes accordingly. The document set attached is my creation of policies and procedures on this matter.

Michael Murphy, L.C.S.W.

PROPER Billing Services
2483 Goose Creek Bypass
Franklin TN 37064
Office: 615-599-1244
Fax: 615-599-8885

# CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

**Billing Information:**

Credit/Debit Card #: _____ Exp. _____

**American Express _____ Discover _____ MasterCard _____ VISA _____**

CW# (3 digits on back of card on the right): _____

Name on Card: _____

Street Address: _____

City/State/Zip: _____

Email Address: _____

**Client Information:**

Client Name: _____

Provider Name: _____

I authorize PROPER Billing Services to charge my credit/debit card in the following manner:

- ☐ Set my account to automatically charge my credit/debit card for the balance due at each visit; or
- ☐ Set my account to have my credit/debit card on file, in the event I fail to pay the balance due on my account by cash or check at each visit, charge my Credit/Debit card for the balance due.

I understand that this charge will show up on my credit/debit card statement as a charge by "Proper Billing Services," who will process my card on behalf of my provider.

_____
Signature of Cardholder

_____
Printed Name of Cardholder

_____
Date

**Internal Use Only**

DOS _____

Ticket: _____ Auth: _____

Amt: _____ Fee: _____

Dep: _____ PD: _____

Rep. TA MC RE DH EM JN AP BS