William L. Mulligan, Ph.D., P.C

# T/A COGNITIVE BEHAVIOR THERAPY CENTER

## Patient Information

Date_____

**Patient Name**: Last _____First _____MI___

Male____ Female ____ Single____ Married ____

Address_____ City_____ ST.___ Zip _____

Phone: H(_____)-_____ Cell (_____) _____W (_____) _____

Email: _____

Patient's Social Security #_____ 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 Co._____ ID _____

Subscriber/s Name _____ SS# _____

Date of Birth _____ Insurance Phone # _____

**SECONDARY INSURANCE**

Secondary Insurance Co._____ ID _____

Subscriber/s Name _____ SS# _____

Date of Birth _____ Insurance Phone # _____

**AUTHORIZATION FOR TREATMENT**

I hereby authorize treatment and/or consultation for the above patient by William L. Mulligan, Ph.D., PC, T/A CBTC 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., P.C. 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 _____

# Financial Agreement

**Co-payments, deductibles and/or payment for any service not covered by your insurance carrier must be paid to WLM, PhD, 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._____

When scheduling an appointment with your therapist, 55 minutes will be reserved for each individual or family session. We realize there may be times when you feel you must cancel an appointment on short notice; however, your therapist will be unable to offer this time to another patient, if we are not given adequate notice. Therefore, **a charge of $125 will be imposed if any appointment is cancelled with less than 24 hours notice, regardless of the reason. For appointments that are scheduled on a Monday, we require cancellations by 5:00pm, the Saturday preceding the appointment. This late cancellation charge must be paid before scheduling your next appointment, and it is important to note that Insurance plans will not cover these charges. _____**

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 PhD, 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

# Court Testimony Agreement
## For Clients in Individual, Marital or Family Therapy

This document represents a binding contract between the parties signed below, who have each agreed to participate in 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 use any information given during the therapy process against any of the other parties in a judicial setting of any kind, be it civil, criminal, or circuit. Furthermore, all parties agree that they will not attempt to subpoena the testimony or treatment records of any professional employee of William L. Mulligan, PhD, PC, hereinafter collectively referred to as Professional(s), for a deposition or court hearing of any kind, for any reason.

**Nevertheless, should any Professional(s) be required to testify 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 $250 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. Given that each Professional will have to cancel at minimum 4 hours of therapy appointments and will have to make necessary preparations, the court-related minimum fee for any court-related testimony will be $2,000.00, for each Professional, which must be paid 10 days in advance of any scheduled court hearing.**

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

Signed _____ date _____

Signed _____ date _____

Signed _____ date _____

1403 Greenbrier Parkway • Suite 215 • Chesapeake • VA 23320
1604 Hilltop West Executive Center • Suite 318 • Virginia Beach • VA 23454
Tel: (757) 410-0700 • Fax: (757) 222-3384
Website: www.doctormulligan.com • email: wlm@doctormulligan.com

# 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 PhD, 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 other side)*

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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 ten years). 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, PhD, at: 1403 Greenbrier Parkway, Suite 215, Chesapeake, VA 23320 or the Secretary of the U.S. Department of Health and Human Services.

**CBT Center Pre-evaluation Questionnaire (Adult)**

Please bring the completed form to your *first* visit to expedite the evaluation process

**Name:** _____ Age:_____ DOB:_____

**Today's Date:**_____ **Race:**_____

**Marital Status:**

- ❑ Married #yrs___ 1st marriage? ❑ Y ❑ N
- ❑ Divorced Date:_____ #yrs married:____
- ❑ Separated Date:_____
- ❑ Single
- ❑ Cohabiting
- ❑ Widowed

**Children:**

| *Age* | *Sex* | *At Home* |
|---|---|---|
| _____ | _____ | ❑ |
| _____ | _____ | ❑ |
| _____ | _____ | ❑ |
| _____ | _____ | ❑ |
| _____ | _____ | ❑ |

**Patient:**

Highest grade level achieved: _____

Present occupation: _____

Years in position or with company: _____

Previous occupation: _____

Years in position or with company: _____

Military Status: _____

Religion: _____

**Patient's partner/spouse :**

Highest grade level achieved: _____

Present occupation: _____

Years in position or with company:_____

Military Status: _____

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

_____

_____

_____

_____

_____

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

_____

_____

_____

**In the past year, have you had any changes in or difficulties with:**

Family/Relationships? _____

_____

_____

Legal Matters/Police? _____

_____

Work/School? _____

_____

Financial? _____

_____

Health (self)? _____

_____

Health (significant others)? _____

_____

Do you have a history of deliberately hurting yourself (i.e., cutting self, taking overdose) or threatening to harm yourself? Please describe: _____

_____

## TREATMENT/MEDICAL HISTORY

***History of Psychological/Psychiatric Treatment***

Have you ever been hospitalized for anxiety, depression, substance use, or any other emotional problem? ❑ Yes ❑ No

Date Hospital Reason

_____

_____

_____

Have you ever received any outpatient treatment or evaluations for any emotional, substance abuse, or personal difficulties? ❑ Yes ❑ No

Date Clinic/Doctor Reason

_____

_____

Are you *currently* taking any medications for anxiety, depression, or any other emotional problem (include sleep medication)? ❑ Yes ❑ No

Date Doctor Reason Medication/Dose

_____

_____

_____

_____

Have you *ever* taken any medications for anxiety, depression, or any other emotional problem (include sleep medication)? ❑ Yes ❑ No

Dates Doctor Reason Medication/Dose

_____

_____

_____

_____

_____

Did you ever experience problems with these medications such as side effects, withdrawal problems, etc.?

❑ Yes ❑ No If *yes*, specify: _____

Has anyone in your family (e.g., siblings, parents, grandparents) received a diagnosis or treatment for a mental illness (e.g., anxiety, depression, bipolar disorder, schizophrenia, substance abuse, autism spectrum, ADHD, learning problems)? If so, specify who and what:_____

_____

_____

_____

***Medical History***

What is your height?_____ What is your weight? _____

Are you currently being treated for any physical disease or condition? ❑ Yes ❑ No

If *yes*, specify: _____

Have you ever had to be hospitalized for a physical problem? ❑ Yes ❑ No

Date Hospital/Doctor Reason Comments/Complications

_____

_____

_____

Have you ever had surgery? ❑ Yes ❑ No

Date Reason

_____

_____

_____

_____

_____

Have you ever had a concussion or any head injury? ❑ Yes ❑ No

Date Reason

_____

_____

Do you have any allergies (hay fever, penicillin, medications, etc.?) ❑ Yes ❑ No

If *yes*, specify: _____

How often do you use alcohol? _____

Do you consider your alcohol use a problem for you?_____

Has anyone ever told you your alcohol use is a problem? _____

Do you use tobacco? ❑ Yes ❑ No Type: _____

If yes, packs/chews per day? _____ How many years? _____

How often do you use drugs such as marijuana or methamphetamines? _____

Do you consider your drug use a problem for you? _____

Has anyone ever told you your drug use is a problem? _____

## RELEVANT PSYCHOLOGICAL HISTORY/SYMPTOMS

Have you ever experienced the following symptoms? Check (P) if you had the symptom in the **past**. Check (N) if you are experiencing the symptoms **now**. Mark only those symptoms which have been to a significant degree over a period of time. Write a brief description including date of onset, duration, and any other pertinent information.

| ***Symptom*** | **Past** | **Now** | ***Brief Description*** |
|---|---|---|---|
| **Behavior** | | | |
| Sexually inappropriate behavior | | | |
| Aggressive/abusive behavior toward others | | | |
| Hyper, always on the go, acts as if driven by a motor | | | |
| Works too hard | | | |
| Procrastinates | | | |
| Suicide attempt(s) or gestures, self-injurious behaviors | | | |
| Spends too freely, unable to manage money | | | |
| Impulsive, irresponsible, dangerous behaviors; excessive risk-taking | | | |
| Repetitive behaviors | | | |
| Nervous mannerisms, tics, twitches | | | |
| Unable to keep a job, problems with superiors (employer, supervisor, teacher) | | | |
| Compulsive behavior (gambling, cleaning, checking, sexual) | | | |
| Legal problems | | | |
| Too meek, passive or non-assertive | | | |
| **Feelings** | | | |
| Depressed, sad, down or blue; tearful | | | |
| Anxious, fearful, worries too much; afraid to go out | | | |
| Feels guilty for no good reason, ashamed | | | |
| Angry, resentful, irritable, harbors grudges | | | |
| Bored, unmotivated, lazy | | | |
| Restless, fidgety, tense, stressed | | | |
| Helpless, not in control; fear of losing control | | | |
| Moody, mood swings | | | |
| Loss of enjoyment, disinterested | | | |
| Other unwanted feelings. Please specify | | | |

| **Imagery** | **Past** | **Now** | ***Brief Description*** |
|---|---|---|---|
| Unpleasant, upsetting images | | | |
| Nightmares, bad dreams | | | |
| Negative or inaccurate self-image, body image | | | |
| Other unwanted images | | | |
| **Thoughts** | | | |
| Can't concentrate, mind not clear, easily distracted, mind wanders | | | |
| Thoughts of hurting or killing self or someone else | | | |
| Perfectionist | | | |
| Self-critical, low self-esteem, no confidence, dislikes self | | | |
| Unwanted, intrusive or repetitive thoughts (sexual, violence, bad memories, etc.) | | | |
| Excessively negative, pessimistic, cynical | | | |
| Suspicious, distrustful, wary | | | |
| Poor memory, forgetful | | | |
| Unable to make decisions | | | |
| Dissatisfied with job or career | | | |
| Other disturbing thoughts. Please specify | | | |
| **Sensations** | | | |
| Painful physical sensations (headaches, stomach distress/gas, chest pain, back pain) | | | |
| Racing/pounding heart, excessive sweating, tightness in chest, dizziness | | | |
| Muscle tension | | | |
| Hear or see things that upset or worry you or that you think are odd | | | |
| Low energy or boundless energy | | | |
| Loss of sexual desire | | | |
| Other unwanted sensations. Please specify | | | |

Any additional comments?_____

_____

_____

_____

THANK YOU!