

William L. Mulligan, PhD, PC  
T/A Cognitive Behavior Therapy Center

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*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*

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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

### 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 Litem 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 (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, #Years \_\_\_\_\_ 1<sup>st</sup> marriage?  Y  N

Divorced, Date: \_\_\_\_\_ #Years married: \_\_\_\_\_

Separated, Date: \_\_\_\_\_

Single

Cohabiting, Years: \_\_\_\_\_

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?

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

Family/Relationship:

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Legal matters/Police:

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Work/School:

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Financial:

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Health (self):

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Health (significant others):

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

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**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
<hr/>	<hr/>	<hr/>

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

Date	Clinic/Doctor	Reason
<hr/>	<hr/>	<hr/>

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

Date	Doctor	Reason	Medication/Dose
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Have you *ever* taken any medications for anxiety, depression, or any other emotional problem (include sleep medication)? Yes  No

Date	Doctor	Reason	Medication/Dose
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Did you ever experience problems with these medications such as side effects, withdrawal problems, etc.? Yes  No

If yes, specify:

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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:

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***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
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Have you ever has surgery? Yes  No

Date	Reason
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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, pack/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?

### Symptom Check List

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 problematic. Write a brief description including date of onset, duration, and any other pertinent information.

<i>Symptom</i>	Past	Now	Brief Description
<b>Behavior</b>			
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, porn)			
Legal problems			
Too meek, passive or non-assertive			
Drinks/eats too much, Smokes, chews, snuff			

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Symptoms	Past	Now	Brief Description
<b>Emotions/Feelings</b>			
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.			
<b>Imagery</b>			
Unpleasant, upsetting images			
Nightmares, bad dreams			
Negative or inaccurate self-image, body image			
Other unwanted images			
<b>Thoughts</b>			
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			

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Symptoms	Past	Now	Brief Description
Unwanted, intrusive or repetitive thought(s) (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 thought(s). Please specify			
Pain (chronic or intermittent 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 or medical disorder			
Overweight			

**Any additional comments?**

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Thank you!