Michelle Malloy M.S., MFT
1107 East Chapman Avenue #203
Orange, CA 92866
(714) 837-8997

Please complete this information form, and please read and sign the attached Informed Consent before your first intake session. Any questions or concerns you may have can be addressed during the intake session.

Today's Date:_____ Referred By:_____

Name:_____
First Middle Last

Address:_____
Number Street (Apt#) City State Zip

Home Telephone:_____Work/Cell:_____

Social Security No.:_____Date of Birth:_____

Currently Employed: Yes No

Occupation:_____

Marital Status: Single Married Relationship Domestic Partner Divorced Widowed

If Patient is a minor, please complete the following section:

Parent's Name:_____
First Middle Last

Address:_____
Number Street (Apt#) City State Zip

Parent's Social Security No.:_____ Date of Birth_____

Patient Medical Information:

Patient's Physician:_____

Address:_____
Number Street (Apt#) City State Zip

Office Telephone:_____ Fax Number:_____

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Current Medications:_____

For what Medical/Psychiatric Condition:_____

Allergies:_____

Person to contact in case of an emergency:

_____
Name/Relationship Address Phone No.

Treatment: I am pleased that you have selected me for psychotherapy services. This document is designed to inform you about my philosophy as a therapist and to ensure you understand our professional relationship. I am a licensed Marriage and Family Therapist. I work primarily with a cognitive behavioral therapeutic orientation. I also utilize exposure response prevention and psychodynamic techniques as needed. Through this, I seek to provide an environment which enhances your understanding of yourself, as I believe that people can and do make important and positive changes based on this insight and in the process of seeking to acquire it.

Treatment Risks: Participation in psychotherapy can result in a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek treatment. Psychotherapy does involve some risks, including the possible experience of intense feelings such as sadness, anger, fear, or guilt. Please remember that these experiences are natural and normal, and they are an important part of the psychotherapy process. Sometimes, in psychotherapy, clients choose to make major life decisions, including decisions regarding family, relationships, employment and lifestyles. Decisions made during the psychotherapy process may result from calling into question old beliefs and values, and these decisions may bring about changes not originally intended. The ultimate outcome of psychotherapy cannot be guaranteed.

Patients who are dependents: As the parent or guardian, you have a right and responsibility to question and understand what occurs in therapy with your child. It is also important that your child be able to trust the therapy process. Therefore, clinical discretion will be used with regard to what is appropriate disclosure of information. You can expect disclosure of information that is important to your child's progress and to your participation in the treatment. If you are the custodial parent in a divorced relationship with your child's other parent, please provide a copy of your court custodial order.

Service charges and financial information: Fees include $150 for the initial assessment session, $150 for 45-50 minute psychotherapy sessions, and $225 per 75 minute session (generally for exposure or family psychotherapy sessions). If you would like to use insurance coverage to pay for your therapy, you will be provided with a superbill. This superbill can then be submitted to your insurance company for reimbursement. Please be aware that if you choose to provide this receipt for services to your insurance company, it must include a psychiatric diagnosis describing you/your minor child. In that event, I will inform you about the diagnosis that I plan to render before it is given. Any diagnosis that is made will become part of your permanent insurance records. A superbill is no guarantee of reimbursement. You are responsible to know the limits and specifics of your insurance coverage, including co-payment amounts and deductibles of your insurance coverage. This information can often be found in your employer's benefits summary booklet. I can help you clarify your benefits information and coverage.

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Please note: *Regardless of your insurance coverage, you are solely responsible for any charges incurred. With most insurance companies, there are procedures you can follow to appeal denied charges. Ultimately, if your insurance company denies payment for services, you are responsible for the charges incurred.*

Confidentiality of information: You have the right to a confidential relationship with your therapist. Information revealed by you during the course of psychotherapy will be kept confidential and will not be released to any agency or other person without your written permission. There are important exceptions to confidentiality that are required by law and outlined herein:
If you threaten to harm yourself
If you threaten to harm someone else
Where there is any suspected child abuse, neglect, or molestation
Where there is any suspected physical, emotional, or fiduciary abuse of an elderly or dependent adult
Psychotherapists must release information subpoenaed by the court as appropriate

It is important to remember that confidentiality of session material cannot be guaranteed in a family or couples psychotherapy situation. Please understand that each family member participating in psychotherapy has a responsibility to maintain confidentiality for the other participating members to ensure the best chances for success.

Appointments and cancellation policies: Psychotherapy services are by appointment only. The length of an appointment is 50 minutes. Please provide 24-hours notice for any appointments you need to cancel. Because each appointment is reserved specifically for you, it is necessary to charge a late cancellation fee of $75 for appointments cancelled with less than 24-hours notice. If you intend to use insurance to pay for services, please know that your insurance cannot be billed for a missed appointment. You will be responsible for the cancelled session fee.

Messages and emergency procedures: In the case of a life-threatening emergency, please call 9-1-1. If you have a psychiatric emergency, please go to the nearest hospital emergency room and ask for the psychiatrist on duty. If you have a primary care physician, this person may also be contacted to facilitate emergency psychiatric care if you have HMO coverage. If you need to contact me, please telephone my confidential voice mailbox at (714) 837-8997. I return all calls within 24-hours.

Termination of services: Termination of psychotherapy may occur at any time and may be initiated by either you or your therapist. Please contact me if you decide to discontinue your psychotherapy so that we can schedule for a final session. Termination itself can be a very constructive process, and I encourage you to discuss any plans to end your treatment as soon as is necessary. If any referrals are warranted, they will be provided at that time.

Your rights: At any time, you may question and/or refuse therapeutic or diagnostic procedures or methods or request additional information regarding procedures. Please do not hesitate to discuss any concerns and/or complaints with me so that we can work toward a resolution. Concerns can also be brought to the attention of the California Department of Consumer Affairs, and the California Board of Behavioral Sciences.

Independent Practitioner: I am a sole-proprietor and work in my own independent private practice. Although I may refer you for additional treatment, I am not legally connected to or responsible for the work of other practitioners.

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Please read and sign below:

I consent to participation in psychotherapy services with Michelle Malloy, MFT and I agree to the policies of this office as detailed in the above paragraphs. I have had the opportunity to ask questions and clarify my understanding of these policies and there are no misunderstandings or disagreements. I have read, understood, and agree to the "Notice of Privacy Policies" and have received a copy for my records.

Signature:_____ Date:_____

I authorize my insurance carrier to pay benefits associated with my care directly to Michelle Malloy, MFT and I authorize the release of information necessary to coordinate benefits, treatment, and payment (including quality improvement efforts where applicable).

Signature:_____ Date:_____

For minor patients, please read and sign below:

I am the legal guardian or legal representative of the patient, and on the patient's behalf legally authorize Michelle Malloy, MFT to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____ Date:_____
Signature of Legal Guardian/Legal Representative

_____
Relationship to the Patient

Provider:

I have reviewed the above policies and informed consent with the patient and/or parent or guardian and there is no misunderstanding or disagreement.

Signature:_____ Date:_____
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PERSONAL INFORMATION

Name: _____
Date of Birth (D.O.B.): _____
Today's Date: _____

Occupation: _____
How long? _____

IF CURRENTLY MARRIED (or widowed):
Spouse's Name:_____ Age:_____ Date of Marriage: _____

Spouse's Occupation:_____ How Long? _____

If Separated, since when? _____

IF DIVORCED:
Ex-spouse's Name:_____ Age: _____

Date of Marriage: _____ Date of Divorce: _____

IF DIVORCED MORE THAN ONCE:
Ex-spouse's Name:_____ Age: _____

Date of Marriage: _____ Date of Divorce: _____

Ex-spouse's Name:_____ Age: _____

Date of Marriage: _____ Date of Divorce: _____

IF INVOLVED WITH A SIGNIFICANT OTHER (S.O.):
S.O.'s Name: _____ Age: _____

S.O.'s Occupation:_____ How Long? _____

If you live together, since when? _____

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PERSONAL INFORMATION (continued)

IF YOU HAVE CHILDREN:

Name	D.O.B.	Living with you?	If not, where does child live?
_____	_____	**yes/no**	_____
_____	_____	**yes/no**	_____
_____	_____	**yes/no**	_____
_____	_____	**yes/no**	_____
_____	_____	**yes/no**	_____

Other children living with you:

Name(s)	D.O.B.	Relationship to you:
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY OF ORIGIN:

Father's Name:_____ Age:_____ Living? yes/no
If deceased, cause: _____ Your age at time of death: _____

Mother's Name:_____ Age:_____ Living? yes/no
If deceased, cause: _____ Your age at time of death: _____

Step-Father's Name:_____ Age:_____ Living? yes/no
If deceased, cause: _____ Your age at time of death: _____

Step-Mother's Name:_____ Age:_____ Living? Yes/no
If deceased, cause: _____ Your age at time of death: _____

Brothers and Sisters:

Name(s)	Age(s)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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CLINICAL INFORMATION

Please indication with an "X" how often you experience any of the following:

	Never	Seldom	Sometimes	Often
Insomnia……..	_____	_____	_____	_____
Back Pain……..	_____	_____	_____	_____
Concentration Problems……..	_____	_____	_____	_____
Headaches……	_____	_____	_____	_____
Phobias(fears)……..	_____	_____	_____	_____
Nausea……..	_____	_____	_____	_____
Allergies……	_____	_____	_____	_____
Nervousness/Anxiety……..	_____	_____	_____	_____
Loss of temper……..	_____	_____	_____	_____
Fatigue……..	_____	_____	_____	_____
Depression……..	_____	_____	_____	_____
Loss of appetite……	_____	_____	_____	_____
Compulsions……..	_____	_____	_____	_____
Suicidal thoughts……..	_____	_____	_____	_____
Eating disturbances……..	_____	_____	_____	_____
Mood swings……..	_____	_____	_____	_____
Heartburn……	_____	_____	_____	_____
Smoking……	_____	_____	_____	_____
Amount:_____				
Alcohol intake……	_____	_____	_____	_____
Amount:_____				

Generally, how would you describe your state of health?_____

_____

_____

Have you had any previous counseling or psychotherapy? yes/no
Name of clinician:_____From_____ To _____
For what reason? _____

Have you ever been prescribed psychiatric medications? yes/no
Name of physician: _____ From_____ To _____
For what reason? _____

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CLINICAL INFORMATION (continued)

Have you ever been hospitalized for psychiatric reasons? yes/no
Name of hospital: _____ From_____ To _____
For what reason? _____

Has any member of your family ever suffered from anything that could be described as an emotional or psychological problem? yes/no If yes, explain:_____
_____
_____

Has there been any history of domestic violence or child abuse in your family? yes/no If yes, explain: _____
_____
_____

Has there been any history of alcohol or drug abuse in your family? yes/no
If yes, explain: _____
_____
_____

In your own words, state the nature of your problem: _____
_____
_____
_____

How would you rate how serious this problem feels to you? (circle one)

1	**2**	**3**	**4**	**5**
Mildly Upsetting				Extremely Serious

What would you like to accomplish through counseling? _____
_____
_____
_____
_____
_____

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Authorization to Release Information

I, _____, hereby authorize Michelle Malloy, MFT to exchange clinical information and records obtained in the course of my diagnosis and/or treatment with:

_____
_____
_____

This exchange of information and records authorized herein is required for the following purpose(s):

___ Coordination of care/treatment

___ Coordination/allocation of benefits

___ Other: _____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This consent is subject to revocation by the undersigned at any time except to the extent that action has already been taken in reliance herein. If not earlier revoked, this authorization shall terminate one year from the date it was signed.

I have carefully read and I understand the foregoing information. I consent to the release of the above-specified clinical information for the purposes listed above. I further release Michelle Malloy, MFT from any liability incurred from the release or exchange of this information to the above designated persons or agencies.

Signature of Patient_____ Date_____

Signature of authorized and/or responsible individual/guardian:

_____ Date_____