

FOR ALL NEW CLIENTS

of

Mercy Dennis, M.A., L.M.F.T.

Licensed Marriage and Family Therapist

Please review, complete and bring to the first Intake Session the following pages.

Pages 2,3,4 and 5 are for my records.

Pages 6, 7, 8, 9, 10, 11 and 12 are for you to keep for your records.

Mercy Dennis, M.A.

Licensed Marriage and Family Therapist

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INTAKE FORM

Date: _____ Referred by _____
 Please complete the following family information (including yourself) and place an X before the name of those persons living in family home.

X	Name	Birth Date	Family Relationship	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Names and relationship to family of other persons residing with family.

+++++ Name _____ Name: _____

Home _____
 Address: _____

Home _____
 Address: _____

Mailing _____
 Address: _____

Mailing _____
 Address: _____

_____/_____
 Home Phone yes/no/m Cell Phone yes/no/m

_____/_____
 Home Phone yes/no/m Cell Phone yes/no/m

_____/_____
 Work Phone yes/no/m Cell Phone yes/no/m

_____/_____
 Work Phone yes/no/m Cell Phone yes/no/m

_____@_____
 e-mail yes/no

_____@_____
 e-mail yes/no

circle yes if it is OK to contact you at this number.....**circle no** if it is not OK to contact you at this number
circle m if it is OK to leave a message at this number

Intake Information Continued:

Briefly state the reason for seeking therapy:

Individual Therapy Issues: _____

Couple Therapy Issues: _____

Have you ever previously been in therapy?

Name: _____ Name: _____

Therapist: _____

Reason: _____

When: _____

Insurance Information

Health Insurance company: _____

Name of Insured: _____ SS # _____

I.D.Number: _____ Group Policy # _____

Employer: _____

Annual Gross Income: _____ Number of Dependents: _____
(answer only if you are requesting sliding scale fee)

Medical Information

Name: _____ **Name:** _____

Doctor: _____

Date of last Physical Examination:

Date: _____

List any significant Medical conditions, current or past (state year):

_____	_____
_____	_____
_____	_____
_____	_____

List Medications Currently Being Taken:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Additional Medical Information You Consider Important:

_____	_____
_____	_____
_____	_____
_____	_____

(At our first session I will ask you to sign the following.)

Therapy Agreement

I freely choose to enter into a therapy relationship with Mercy Dennis, M.A., L.M.F.T., with the knowledge of the conditions stated in this intake form.

I agree to hold Mercy Dennis harmless and free of liability for abandonment or malpractice if she is not available to me during any circumstances, including the previously mentioned circumstances.

I understand our sessions are for the purpose of psychotherapy, personal growth, conflict resolution, problem solving, personal and interpersonal skill building and/or other as identified during the first intake session between myself and Mercy Dennis. These sessions are not intended to be used for litigation purposes. I agree not to request Mercy Dennis release any information and I agree not to call her to serve as a witness in any litigation I am currently involved in or any litigation I become involved in unless prior agreement is made with Mercy Dennis.

By signing this therapy agreement I indicate that I have completed the Intake Information on pages 2,3,4 and I have read and reviewed page 6, Financial Information: page 7, Emergency Coverage: pages 8 and 9, Professional Disclosure Statement and pages 10, 11,12 , Notice of Policies and Practices to Protect the Privacy of Your Health Information.

I, _____ accept the responsibility to pay for services rendered by Mercy Dennis, L.M.F.T. I guarantee payment for these services as stated under “Financial Policies”, page 6, unless a different agreement between Mercy Dennis and myself is stated below.

_____	_____
signature	date
_____	_____
signature	date

Office and Financial Policies for Mercy Dennis, LMFT

My office policy requires therapy fees to be paid in full by check, cash or credit card at the time of service. The first Intake Session is \$180 and is generally 90 minutes. A regular 50-60 minute therapy session is \$120. An extended session of 75-90 minutes is \$160 and any other exception to this will be discussed and agreed upon in advance. I do offer a sliding fee scale for those folks who request it. This fee is determined by taking into consideration a person or family's yearly gross income, number of dependents, and type of services requested. I also am available to work with a co-therapist if you and your partner or family wishes to work with a co-therapy team.

I do not consider health insurance as payment of your account unless we have made a different specific agreement. Reimbursement for my services is an arrangement between you and your insurance company. It is your responsibility to pay your account with me, and I am willing to provide you with the information you need to file your claims with your insurance company so that you can be reimbursed directly. It is your responsibility to check with your health insurance company to find out what kind of coverage, if any, is provided and what type of providers are covered. I am a Triwest provider and I do work with First Choice and APS Employee Assistance Programs.

In order for you to submit your insurance claims, it may be necessary for me to release information in a very limited nature to the insurance company. Since I maintain strict confidentiality, it will be necessary for you to give me authorization to release information before I report to your Insurance Company. Also, if at any time during your therapy your insurance company requires additional forms after they have received the standard insurance forms there may be an additional fee to cover the additional professional time required to complete these forms or reports. I will notify you of the necessity of this prior to completing them.

I encourage you to be aware of all insurance requirements for your particular health insurance company. If your insurance company or I require a psychiatric/medical consultation, it may be necessary for you to have a session with a psychiatrist or other medical professional. Also, I may request that you consult with another professional for such purposes as psychological testing, addiction evaluation or other. These additional services will be discussed with you as

With less than 24 hours notice, I often have difficulty rescheduling the appointment time reserved; therefore, I request that you notify my office 24 hours in advance of a cancelled appointment. 50% of the session fee is charged for appointments broken or cancelled with less than 24 hours notice.

If you have any other questions about the financial arrangements for my therapy services please feel free to discuss them with me.

EMERGENCY COVERAGE POLICIES

After normal working hours and on weekends when I am in town (and not on vacation), if you feel that you are in a crisis situation and need to reach me immediately you may call my office at 278-5522, leave a message and I will return your call. If you ever feel the need for emergency treatment during or after normal business hours and you are unable to reach me through my office I encourage you to contact your personal support persons or one of the community resources listed below.

I will tell you in advance when I plan to be out of town or on vacation for an extended period of time. I encourage you to let your personal support system know that you may need extra support during this time. I will also make previous arrangements with another therapist to accept emergency calls and referrals during my absence. This information will be on my voice mail message. If you choose to use the services of this therapist you will be required to make separate financial arrangements that that therapist.

Community Resources in Anchorage

Ambulance/Police/Fire.....	911
Suicide Prevention and Crisis Line.....	563-3200
Poison control.....	1-800-222-1222
Abused Women Aid in Crisis Shelter.....	279-9581
AWAIC 24 hour crisis line.....	272-0100
STAR (Rape Crisis Line).....	276-7273
Alaska Women's Resource Center.....	276-0528
Men and Women's Center.....	272-4822
Providence Alaska Medical Center.....	562-2211
Alaska Regional Hospital.....	276-1131
Alaska Native Medical Center.....	563-2662
U.S. Air Force Elmendorf Hospital.....	580-6260

Professional Disclosure Statement

Following completion of a B.S. degree in Elementary Education in 1966 from the University of North Dakota and after teaching for seven years, I returned to graduate school in 1973 to pursue a Master's Degree in counseling. I completed a M.A. degree from the University of North Dakota in 1975 which included coursework specifically in the field of Marital and Family Therapy at Florida State University. I continued with a year of Post Master's work with a focus on Marital and Family Therapy at UND. In 1976 I moved from North Dakota settling in Alaska with my new husband, two children and dog.

Over the past 30+ years I have worked with clients in a variety of settings including family service agencies, inpatient mental health treatment units in a psychiatric hospital and a general hospital, and a private practice. I have practiced Marital and Family Therapy in the Anchorage area since 1976. The areas of focus of my current private practice are as follows:

1. Individual Therapy
 - a. Women, men and, adolescents
2. Couple Therapy and Couple Groups
 - a. Relationship/Couple/Marital Therapy -
 1. Recent focus of couple and relationship training training with John and Julie Gottman of the Gottman Institute in Seattle, the Gottman Method of Couple Therapy
 2. training with Brent Atkinson using "Developing Habits for Relationship Success"
 3. training with Terry Real, Relational Recovery Institute
 4. training in Imago Education
 - b. Relationship Coaching
 - c. Pre-Marital Therapy
 - d. Pre-Divorce and Divorce Therapy including Co-Parenting
3. Family Therapy
4. Cooperative Parenting
 - a. Cooperative Parenting and Parent Coordination
 1. training with Susan Boyum, Director of the Cooperative Parenting Institute in Atlanta
5. Mediation for people in relationship disputes relating to divorce, family, job, parent/adolescent, etc.

Confidentiality of Communication:

A licensed Marital and Family Therapist in the State of Alaska may not reveal to another person a communication made to the licensee by a client about a matter concerning which the client has employed the licensee in a professional capacity. This does not apply to

- 1) a case conference or case consultation with other mental health professionals at which the patient/client is not identified;
- 2) the release of information that the client in writing authorized the licensee to reveal;
- 3) information released to the board as part of a disciplinary or other proceeding;
- 4) situations where the rules of evidence applicable to the psychotherapist-patient privilege allow the release of the information;
- 5) a communication to a potential victim or to law enforcement officers where a threat of imminent serious physical harm to an identified victim has been made by a client; or
- 6) a disclosure revealing a communication about an act that the licensee has reasonable cause to suspect constitutes unlawful or unethical conduct that would be grounds for imposition of disciplinary sanctions by a person licensed to provide health or mental health services, if the disclosure is made only to the licensing board with jurisdiction over the person who allegedly committed the act, and the disclosure is made in good faith.

Notwithstanding the above, a Licensed Marital and Family Therapist shall report incidents of

- 1) child abuse or neglect
- 2) harm or assaults suffered by an elderly person or disabled adult

See the "Notice of Policies and Practices to Protect the Privacy of your Health Information" (pages 10,11,12,13) for an additional explanation of the confidentiality regulations set forth by state and federal regulation for Marital and Family Therapists.

This information is required by the Alaska Board of Marital and Family Therapy, which regulates all Licensed Marital and Family Therapists in Alaska.

State of Alaska:
Board of Marital and Family Therapy
P.O. Box 110806
Juneau, Alaska 99811-0806
907-465-2551

Notice of Policies and Practices to Protect the Privacy of Your Health Information

This notice is required by the federal government under the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment, and other health care operations. This notice describes how your information may be used and disclosed and how you can access this information. I am required to obtain your signature indicating that you have received this notice. Please note that this required notice details only minimum protections. I have opted to increase protection of your information as described in the last section of this document.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your general consent to treatment. To help clarify these terms, here are some definitions:

- PHI refers to information in your health record that could identify you.
- Treatment, Payment and Health Care Operations: Treatment is when I provide, coordinate or manage your health care and other related services. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health practitioner. Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine your coverage. Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality improvement activities and business-related matters such as audits and administrative services.
- Use applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose your PHI for purposes outside of treatment, payment, or health care operations only with your authorization. An “authorization” is specific written permission. When I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes if they are maintained separately. “Psychotherapy Notes” are notes I may have made about our conversation during a private, group, joint, or family counseling session, which may or may not be kept separate from the rest of your record.

You may revoke, in writing, all such authorizations at any time. You may not revoke an authorization to the extent that (1) I have already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest a claim for payment.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose your PHI without your consent or authorization in the following circumstances:

- Child Abuse - If I, in the performance of my occupational duties, reasonably suspect that a child has suffered harm as a result of child abuse or neglect, I must immediately report the harm to the appropriate authority.
- Adult and Domestic Abuse - If I, in the performance of my occupational duties, have reasonable cause to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self-neglect, then I must report that belief to the appropriate authority.
- Health Oversight Activities - I may disclose PHI to the appropriate board of the Alaska Division of Occupational Licensing or Department of Community and Economic Development in proceedings conducted by the board or the department where the disclosure of confidential communications is necessary to defend against charges before the board or department.
- Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.
- Serious Threat to Health or Safety - I may disclose PHI where you communicate an immediate threat of serious physical harm to an identifiable victim. If you present an imminent risk of serious harm to yourself, I may disclose information necessary to protect you.

IV. Patient's Rights and Practitioner's Duties

Patient's Rights:

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, if you do not want a family member to know that you are seeing me.)
- Right to Inspect and Copy - You have the right to inspect and/or obtain a copy of PHI in my records for as long as they are retained with limited exceptions. On your request, I will discuss the request process with you. There may be a fee for copying your records.
- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss the amendment process with you.
- Right to an Accounting - You have the right to receive an accounting of disclosures of PHI that were made without your authorization (those in Section III of this notice). On your request, I will discuss the accounting process with you. There may be a fee for time required to compile this information.
- Right to a Paper Copy - You have the right to obtain a paper copy of this notice from me upon request.

Practitioner's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide or make the revisions available to you. If you are a current patient, I will provide you with a revised copy in person or by mail. If you are a former client, not currently receiving services from me, the most current revision of this notice will always be available from my website at www.mercydennis.com (look for "Forms"), or you can request a copy directly at any time.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please discuss these with me. If you are dissatisfied with the outcome of that discussion, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

Please note that this notice is a minimum standard dictated by state and federal laws. The same laws allow me to further limit the uses or disclosures that I will make without your consent. I have chosen to further protect your confidentiality by requiring specific authorization for any disclosure in section I of this notice unless you choose to provide general consent for those purposes. This does not affect the uses and disclosures in section III of this notice that do not require your consent.

This notice is effective as of May 19, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain.