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 2,3,4,5,6 and 7 are for my records.

Pages 8, 9, 10, 11,12 and 13 are for you to keep for your records.

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Anchorage Alaska 99501

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907-278-5522
www.mercydennis.com

Mercy Dennis, M.A., LMFT

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: (Age)	Family Relationship:	Occupation:
__	_____	_____(____)	_____	_____
__	_____	_____(____)	_____	_____
__	_____	_____(____)	_____	_____
__	_____	_____(____)	_____	_____
__	_____	_____(____)	_____	_____
__	_____	_____(____)	_____	_____

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

_____

Name_____ **Name:**_____

Home Address
_____

_____

Mailing Address
_____

_____

_____/_____
Home Phone Cell Phone

_____/_____
Work Phone Other Phone

_____
e-mail

Home Address
_____

_____

Mailing Address
_____

_____

_____/_____
Home Phone Cell Phone

_____/_____
Work Phone Other Phone

_____
e-mail

Briefly state the reason for seeking therapy:

Individual Therapy Issues:_(name:_____)_____

_____

_____

Individual Therapy Issues:_(name:_____)_____

_____

_____

Couple Therapy Issues:_(name:_____)_____

_____

_____

Couple Therapy Issues:_(name:_____)_____

_____

_____

Have you ever previously been in therapy?

Name:_____ Name:_____

Therapist: _____ Therapist: _____

Reason: _____ Reason: _____

When: _____ When: _____

Insurance Information

Health Insurance Company:_____ Employer:_____

Name of Insured:_____ SS #_____

I.D.Number: _____ Group Policy # _____

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

HEALTH INFORMATION: **under your name complete the following information.**

Client Name:_____ **Client Name:**_____

Doctor:_____ _____

Date of last
physical examination: _____ _____

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

_____ _____

_____ _____

_____ _____

_____ _____

List medications currently being taken:

Medication: _____ *Medication:*_____

How often? _____How much? _____ How often? _____How much? _____

Medication: _____ *Medication:*_____

How often? _____How much? _____ How often? _____How much? _____

Medication: _____ *Medication:*_____

How often? _____How much? _____ How often? _____How much? _____

Medication: _____ *Medication:*_____

How often? _____How much? _____ How often? _____How much? _____

Additional Medical Information You Consider Important:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

INTAKE INFORMATION CONTINUED:

Client Name:_____ Client Name:_____

RECREATIOINAL DRUGS: What:

EXPLAIN USE: How Much and How Often and Benefit:

RECREATIOINAL DRUGS: What:

EXPLAIN USE: How Much and How Often and Benefit:

RECREATIOINAL DRUGS: What:

EXPLAIN USE: How Much and How Often and Benefit:

ALCOHOL: What:

EXPLAIN USE: How Much and How Often and Benefit:

ANXIETY: EXPLAIN:

DEPRESSION: EXPLAIN:

RECREATIOINAL DRUGS: What:

EXPLAIN USE: How Much and How Often and Benefit:

RECREATIOINAL DRUGS: What:

EXPLAIN USE: How Much and How Often and Benefit:

RECREATIOINAL DRUGS: What:

EXPLAIN USE: How Much and How Often and Benefit:

ALCOHOL: What:

EXPLAIN USE: How Much and How Often and Benefit:

EMOTIONAL AND BEHAVIORAL SYMPTOMS:
Under you name please explain the stressors, which you have experienced over the past 3 months and place a check mark next to the symptoms, which you have experienced:

Name:_____ Name:_____

STRESSORS: _____ _____

_____ _____

_____ _____

Insomnia-Sleep Disturbance
_____ Difficulty Getting to Sleep: _____
_____ Interrupted Sleep-Waking During: _____
_____ Restlessness: _____
_____ Early Morning Wakening: _____

Appetite Disturbance
_____ Overeating: _____
_____ No Appetite: _____
_____ Nausea When Eating : _____

Depressive Symptoms
_____ Feeling of Sadness: _____
_____ Frequently Tearful: _____
_____Low Energy Level: _____
_____ Low Motivation: _____
_____ Difficulty Concentrating: _____
_____ Feeling of Hopelessness: _____

Anxiety Symptoms
_____ Feeling Fearful, Scared: _____
_____ Feeling Nervous: _____
_____ Worrying: _____
_____ Difficulty Focusing: _____
_____ Feeling Jittery: _____
_____ Self-Defeating Behaviors Perpetuating Anxiety: _____

Daily Living Problems
_____ Ineffective Coping Skills: _____
_____ Ineffective Problem Solving Skills: _____
_____ Interpersonal Relationship Impairment: _____

Perceived Lack of Control
_____ Feeling Out of Control: _____
_____ Behaviorally Out of Control: _____
_____ Impairment in Work/School Functioning: _____

(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 2,3,4,5, 6 and I have read and reviewed page 8, Financial Policies: page 9, Emergency Coverage: page 10, Professional Disclosure Statement: Page 11, Confidentiality Info: pages 12,13, Notice of Policies and Practices to Protect the Privacy of My 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 8, unless a different agreement between Mercy Dennis and myself is stated below. *For appointments cancelled with less then 24 hours notice I agree to accept that 50% of the therapy fee will be charged to a credit card on file or will be billed to me.*

_____

_____

signature: date:

_____

signature: date:

_____

Therapist signature: date:

_____

Mercy Dennis, M.A., L.M.F.T. Office Policies ***(2017)***

My policies require therapy fees to be paid in full by check, cash or credit card at the time of service.

--The first **Intake Assessment Session** is **$250.00** and is generally 90 minutes.
--Following **couple sessions** are 90 minutes, scheduled every two weeks and are **$225**. I have determined that this schedule and timing for couples is the most effective as it allows us to focus on the couple's concerns and skills during the session and it gives the couple two weeks to practice what was learned during the session. If it is determined that more frequent 60 minute sessions are more effective the rate is **$180.00** per session.
--Generally, **individual sessions** are a regular 50-60 minute therapy session and are **$180.** An extended session of 90 minutes is **$225.**
--A 90-minute **group therapy** or consultation group session is **$50.00** per person. --Any other exception to this will be discussed and agreed upon in advance.
--Any time spent on essential **reports or consultations** will be prorated on the **$180.00** per hour rate.
--I also am available to work with a co-therapist if you and your partner or family wish to work with a co-therapy team. The co-therapy team will determine the billing.

I do not consider health insurance as payment of your account unless we have made a 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. Services may be covered in full or in part by your health insurance or employee benefit plan. You may want to check your coverage carefully by asking the following questions:

- Do I have mental health benefits?
- What is my deductible and has it been met?
- How many sessions per calendar year does my plan cover?
- How much does my plan cover for an out-of-network provider?
- What is the coverage amount per therapy session?
- Is preapproval required?

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. 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, medication evaluation, addiction evaluation or other. These additional services will be discussed with you as soon as I become aware of their need; as you will be responsible for their costs.

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

If you have any other questions about the office policies or 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 or email at info@mercydennis.com, leave a message and I will respond ASAP . 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 with 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 41+ 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 with relationship focus
    i) Women and Men

2. Couple's Therapy
    i) Relationship/Couple/Marital Therapy -Recent focus of couple and relationship training:
        (1) training with Terry Real, Relational Life Therapy
        (2) training with John and Julie Gottman of the Gottman Institute in Seattle, the Gottman Method of Couple Therapy
        (3) training with Brent Atkinson using "Developing Habits for Relationship Success"
        (4) training in Imago Education
        (5) training In Ellen Bader's Developmental Model
        (6) training with Ester Perel, working with Infidelity
    ii) Relationship Coaching
    iii) Pre-Marital Therapy
    iv) Pre-Divorce and Divorce Therapy including Co-Parenting
    v) Divorce Recovery Coaching

3. Cooperative Parenting
    i) Cooperative Parenting
    training with Susan Boyum, Director of the Cooperative Parenting Institute in Atlanta

This information is required by the Alaska Board of Marital and Family Therapy, which regulates all Licensed Marital and Family Therapists in the State of Alaska.
Should you feel that I have violated the AAMFT Code of Ethics or a state or federal statues, regulations and/or laws, you have the right to report me for unethical conduct. If you feel the need to file a grievance or complaint, you may contact the following:

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

The American Association for Marriage and Family Therapy (AAMFT)
12 South Alfred Street,
Alexandria, VA 22314-3061
(703) 838.9808 ethics@aamft.org

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. 1) a case conference or case consultation with other mental health professionals at which the patient/client is not identified;
2. 2) the release of information that the client in writing authorized the licensee to reveal;
3. 3) information released to the board as part of a disciplinary or other proceeding;
4. 4) situations where the rules of evidence applicable to the psychotherapist-patient privilege allow the release of the information;
5. 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. 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.

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.