Dr. Mary Murphy, Ph.D.
Licensed Clinical Psychologist
CT#003358, NPI#1528229572
25 Church Hill Road, Suite 102
Newtown, CT 06470
203-689-7193

CENTER FOR ASSESSMENT AND PSYCHOTHERAPY

Authorization Consenting Release of Information

I authorize Dr Mary Murphy, PhD to **discuss** verbally and or in writing anything that has been brought up during the course of our psychotherapy or evaluation **with** any person/s or staff of clinic, office, agency, or institution/s named below and **receive** any relevant information or records from them.

_____

(insert name of person Dr. Murphy can speak with and receive information /records from)

For the following reason(s):

____ Consultation/Psychotherapy,

____ Evaluation,

____ Coordination of care,

____ Other: _____

I may revoke this consent at any time. This consent is in effect for five years from the date of the last session, unless revoked in writing earlier or renewed. I understand that this release may contain information related to psychiatric records. This consent is also subject to all conditions outlined in our Office Policies and is governed by all state privacy laws as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I further understand that any digital or typed signature is intended to substitute for my valid, authorized, legal ink signature. When signing for a minor, I represent and confirm that I have full legal authority to provide consent for this minor.

_____	_____	_____
Patient Name (print)	Signature	Date
_____	_____	_____
Parent / Guardian Name#1 (print)	Signature	Date
_____	_____	_____
Parent / Guardian Name#2 (print)	Signature	Date

CENTER FOR ASSESSMENT AND PSYCHOTHERAPY

Credit Card / Recurring Payment Authorization Form

The Center for Assessment and Psychotherapy including the offices of Dr. Mary Murphy, Ph.D., LLC., and Dr. Diana Naddeo, Psy.D., LLC, requires a credit or debit card on file for all services. I Authorize **Dr. Mary Murphy, PhD**:

- to make charges to my Visa, MasterCard, American Express, or other card after each therapy or testing session.
- to charge my card for missed therapy appointments or late cancellation fees (if less than 24 hours notice) in the amount of a full therapy session fee, $250 missed appointment or late cancellation fees (if less than 24 hours notice) for testing appointments, and insufficient check amounts plus insufficient check fee of $30 per bad check.

If I have questions about these charges, I agree to contact **Dr. Mary Murphy, PhD**. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

If these charges are for someone other than myself (enter person's name and your relationship to them below):

_____ _____

Name **Relationship**

Please complete the information below:

I _____ ***Name (as it appears on credit card)*** authorize **Dr. Mary Murphy, PhD** to to charge my credit card, indicated below, on the day in which I receive my therapy session.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Please make sure the following information is accurate.

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____ CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

Dr. Mary Murphy, Ph.D., LLC & Dr. Diana Naddeo, Psy.D., LLC
25 Church Hill Road, Suite 102
Newtown, CT 06470

CENTER FOR ASSESSMENT AND PSYCHOTHERAPY

Adult Background and History Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Enter "N/A" if not applicable.

PERSONAL INFORMATION

Identifying Information
Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Address: _____

Contact Information
Cell: _____ Email: _____

Messages: check next to each place where a provider or staff of CAP can leave you confidential messages:
Phone #_____ Email: _____ Text: _____

Person & phone number to contact in emergency:

Name: _____ Phone: _____

Gender Identification: Sex Assigned at Birth: _____ Gender Identity: ☐Male ☐Female ☐Other_____

Preferred Pronouns: _____

Religious Preferences/Affiliation: _____

Race/Ethnicity: _____

Marital Status:
☐Single ☐Married ☐Divorced ☐Cohabitating ☐Separated ☐Widowed ☐Other.

If you have a partner or spouse, how long have you been together? _____
If you are divorced, when did you divorce? _____
If you are widowed, when and how did your spouse die_____
If applicable, please list names and ages of your children:

CENTER FOR ASSESSMENT AND PSYCHOTHERAPY

REASON FOR REFERRAL/PRESENTING PROBLEM
Who referred you here: _____

Presenting Problem: briefly describe why you were referred for an evaluation and how this problem currently affects you:
_____
_____
_____
_____
_____

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

Current Symptoms Checklist: (check all that apply)
☐ Depressed mood ☐ Excessive talking ☐ Unreasonable fear ☐ Lost or gained weight

☐ Racing thoughts ☐ Fear of social situations ☐ Not enough sleep ☐ Easily distracted

☐ Repetitive thoughts/behavior ☐ Too much sleep ☐ Over working yourself ☐ Upsetting memories

☐ Sluggish ☐ Impulsive behavior ☐ Recent loss/grief ☐ Agitated

☐ See/hear things that are not real ☐ Work/school problems ☐ Violent thoughts/behaviors

☐ Cannot concentrate ☐ Tense/unable to relax ☐ Afraid to leave home ☐ Excessive worry ☐ Anger outburst

☐ Inflated self-esteem ☐ Panic attacks ☐ Careless, high-risk behavior ☐ Feel guilty or worthless

☐ Thoughts of death or suicide

DEVELOPMETNAL AND FAMILY HISTORY
Describe your childhood, generally (who did you live with, nature of relationships with parents/caregivers, siblings, etc.)_____
_____
_____

Where did you grow up: _____ Same town entire life? ☐Y ☐N
If you moved, please explain below:

Age(s)	Place
_____	_____
Age(s)	Place
_____	_____

If parents divorced: Your age at the time: _____Describe how it affected, you at the time:
_____
_____

Before the age of 16, to what degree did you experience the following:

	None	Slight	Mild	Moderate	Severe
A chaotic home environment (e.g., frequent fighting, minimal structure, etc.)	0	1	2	3	4
Emotional reactions from your primary caregiver(s) that did not match the severity of what happened (e.g., extreme anger to a small mistake or minimal reaction to an abusive or harsh situation)	0	1	2	3	4
Emotional neglect, meaning your problemsand experiences were ignored, and you felt that there was no attention or support fromyour primary caregiver	0	1	2	3	4
Psychological abuse at home (yelled at, falsely punished, subordinated to your siblings, or blackmailed)	0	1	2	3	4
Physical abuse (hit, kicked, beaten up orother types of physical abuse)	0	1	2	3	4
You were bullied, socially ostracized, or had difficulties making friends	0	1	2	3	4
You were disciplined or reprimanded by teachers, including sent home, or suspendedfrom school, etc.	0	1	2	3	4
You missed a lot of school	0	1	2	3	4
Financial hardship or strain	0	1	2	3	4

EDUCATIONAL/OCCUPATIONAL HISTORY

Highest grade/degree completed: _____

Type of degree: _____

If still in school, which do you attend? _____

When you were in school did you have an IEP or 504 at any time?

_____

_____

Did you ever repeat a grade? If yes, what grade(s)? and reason?

_____
_____

Were you ever in any special education class(es) or did you receive special services for learning difficulties?

_____
_____

Are you currently working? ☐ Yes ☐ No If yes, what are you doing?

_____
_____

Occupation (job title, student, retired, etc.): _____

How long have you been at your current job? _____

What kinds of jobs have you had in the past if different than your current job?

_____
_____

What kind of work do you hope to do in the future?

_____
_____
_____

PSYCHIATRIC HISTORY

Have you previously been in psychotherapy or counseling, including individual, group, marital orfamily therapy?
☐Yes ☐No

If yes, please provide the following information in the table below:

Name of provider	Date(s) of treatment	Problem for which treatment was sought	Did youfind it helpful?	If yes, in whatway was it helpful?	If not, in what way was it unsatisfactory?
			Y / N		
			Y / N		

Have you ever been hospitalized for mental or emotional difficulties or for drug or alcohol abuse?
☐Yes ☐No If yes, please complete the following chart.

When were you hospitalized?	For how long?	Reasons for hospitalization or partial hospitalization	Was it voluntary?
			Y / N
			Y / N
			Y / N

Do you *currently* take medications or supplements to treat mental/emotional difficulties or substance?If yes, please complete the following chart. (Later in the questionnaire, you will be asked to list medications for medical conditions.)

Medication Name	Dosage/ Frequency	When started?	Name of Prescriber	Prescribed for what symptoms?

Please list medications you have taken previously to treat mental or emotional difficulties or drug oralcohol abuse:

_____

_____

Do any biological relatives have any history of psychiatric, emotional and/or substance useproblems?

	Family Member
Panic attacks or phobias or anxiety	
Depression	
Schizophrenia	
Bipolar disorder	
ADHD	
Learning Disabilities	
Autism Spectrum Disorder	
Other: _____	

CENTER FOR ASSESSMENT AND PSYCHOTHERAPY

MEDICAL HISTORY

Past/Present Medical Care (please include history of lyme, concussions, medical conditions, surgeries, accidents, falls, illness, etc.):

_____
_____
_____
_____

Are you currently taking medications for any physical health problems? ☐Yes ☐No
If yes, please complete the following chart.

Medication Name	When started?	Prescribed for what symptoms?

Family Medical History (Describe any illness that runs in the family e.g., cancer, epilepsy, diabetes, obesity, heart disease):

_____
_____
_____

LEGAL HISTORY

Are you involved in any current or pending civil or criminal litigation/s, DCF cases (past or present), lawsuit/s, or divorce or custody dispute/s? (If you answer Yes, please explain):

_____
_____
_____

Have you ever been involved in any current or pending civil or criminal litigation/s, DCF cases (past or present), lawsuit/s, or divorce or custody dispute/s? (If you answer Yes, please explain):

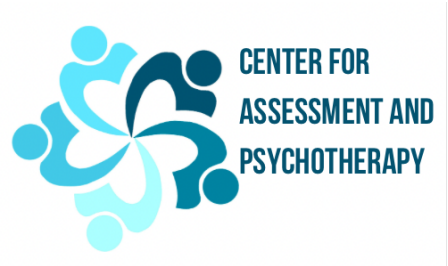
_____
_____
_____

What do you hope to improve during your work in therapy with me:

_____
_____
_____

Is there anything else you would like me to know about you:

_____
_____
_____



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

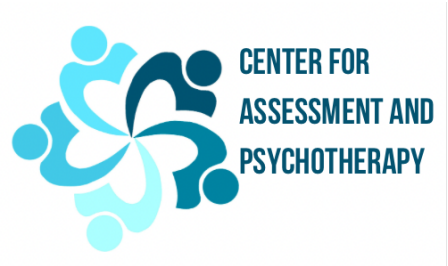
I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Dr. Mary Murphy LLC or Dr. Diana Naddeo, Psy.D., LLC, and of your individual rights and Dr. Mary Murphy LLC and Dr. Diana Naddeo, Psy.D., LLC's legal duties with respect to confidential information.

Ways in which I may use and disclose your protected Health information:

I may use and disclose at my discretion your medical records for each of the following purposes only: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing mental health care and related services.
- **Payment** means activities such as obtaining payment for the mental health care services I provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice. This includes discussion of client information during staff supervision meetings and care coordination amongst our clinical staff and interns.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care.



I will use and disclose your protected health information when required by federal, state or local law. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to persons or agencies even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing a I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand my operation use of your information for treatment, payment and health care operations as stated above.

_____ _____

Printed Name Date

_____

Signature

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