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 _____

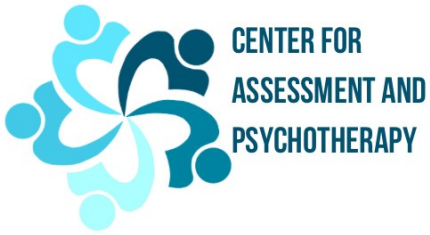
Account Number _____

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




**PEDIATRIC PSYCHOLOGICAL SERVCIES**
**Developmental, Social, and Behavioral Intake Form**

***Please fill out this form as completely as possible. The information will help me in our work together regardless of the child's age at the time of testing. Information is confidential as outlined in the Informed Consent for Assessment Services Office Policy form and the HIPAA Notice of Privacy Practices. Enter "N/A" if not applicable.***

Date Form Completed: _____

Person Completing the Form: _____ Relationship to Client: _____

**Demographics**
Client's Name: _____ Nickname: _____
Preferred Pronouns: _____ Gender: _____
Sex Assigned at birth: _____ Gender Identity: _____
Date of Birth: _____ Age: _____
Home Address: _____
_____

Person and Phone Number to contact in Emergency:
_____
_____

Guardian#1:_____Email: _____
Occupation:_____ Cell: _____
Email: _____

Guardian#2_____ Email: _____
Occupation:_____ Cell: _____
Email: _____

For Messages (place checkmark next to each place I can leave you confidential messages):
Phone #_____ Email: _____ Text: _____
Indicate which Guardian should be messaged: _____

**Reason for Referral for Evaluation/Assessment:**
- ☐ Diagnostic clarity
- ☐ Request for school accommodations (e.g. 504 Plan, IEP, college disability services, etc.)
- ☐ Psychotherapy
- ☐ Other: _____

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**Developmental/Prenatal History**

Age of Mother at Child's Birth _____ Age of Father at Child's Birth_____

Did the mother receive prenatal care? ☐Yes ☐No

Complications during pregnancy: _____

Medications/Drugs used during pregnancy: _____

Child's birth weight_____

Birth Injury or complications at birth_____

Please describe pregnancy attempts (i.e. was pregnancy planned, pregnancy losses, were you trying for lengthy amount of time, stresses while trying to conceive, etc.):

_____

_____

_____

**Early Developmental History**

Who was the primary caregiver during infancy (mom and dad, au pairs, grandparents/ other family member, etc.)?

_____

_____

Please describe the postpartum period (i.e., please mark as uneventful or describe stresses including postpartum depression, etc.):

_____

_____

Please describe child's temperament as a young infant (i.e., colicky, fussy, hard to soothe, etc.):

_____

_____

**Developmental Milestones**

Were developmental milestones reached on time, if not please describe if walking/talking/ toileting/ other milestones were not met on time (include need for Speech, PT, OT, birth to 3, etc.):

_____

_____

_____

_____

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Please describe early childhood (i.e., response to separation from parents for daycare/ school, behavior issues including fighting, anxiety, depression, bedwetting, etc.):

_____

_____

_____

_____

**Reason for Referral/Presenting Problem:**

| | | | |
|---|---|---|---|
| **Behavior** | ☐ Physical Aggression<br>☐ Impulsive type/reactive | ☐ Verbal Aggression | ☐Sexual Aggression |
| | ☐ Property Damage | ☐ Inattentive | ☐ Hyperactive |
| | ☐ Impulsive | ☐Defiant | ☐ Social Skills |

| | | | |
|---|---|---|---|
| **Emotional** | ☐ Depressed Mood | ☐ Suicidal Thoughts | ☐Emotional fluctuations |
| | ☐ Increased Agitation | ☐ Sleep Changes | ☐ Marked increase in energy or irritability |
| | ☐Appetite Change | ☐ Victim of Abuse | ☐ Anxious |

| | | | |
|---|---|---|---|
| **Academic** | ☐Reading Difficulties | ☐ Spelling Difficulties | ☐Math Difficulties |
| | ☐ Writing Difficulties | ☐ Speech Difficulties | ☐Reading comprehension difficulties |
| | ☐Overall poor educational progress | ☐ Suspensions/expulsions | ☐ Use of 1:1 para support in school |

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| | |
|---|---|
| **Readiness / Insight** | □ Understands there is a problem and wants help |
| | □ Understands there is a problem and not overly interested in getting help |
| | □ Understands there is a problem and does not want help |
| | □ Does not understand that there is a problem |

Other (please describe):

_____

_____

_____

Describe a history of the identified difficulties and any current stressors (when did the problem start and estimate the severity of problem using Mild, Moderate, Severe or Very Severe):

_____

_____

_____

_____

**Family Information:**

Marital Status:

□ Single □ Partnered □ Married □ Separated □ Divorced* □ Widowed*

*When: _____

Is the child Adopted: □ Y □ N At what Age? _____

Do they know they are adopted? _____

Client Lives with:

□ Biological Mother

□ Biological Father

□ Stepparent

□ Adoptive Parent

□ Grandparent

□ Legal Guardian/Other (please specify) _____

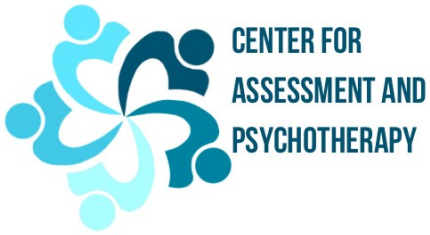
If separated or divorced please provide a description of the amount of time spent in each home:

_____

_____

_____

_____




Same Town Entire Life? □Y □N If No please describe below
Age(s)_____ Place _____
Age(s)_____ Place_____
Age(s)_____ Place_____

Sibling Information (include half and stepsiblings):

| Name of Sibling: | Age: | Relationship to Child: | Lives with Child: |
|---|---|---|---|
| | | | □Y □N |
| | | | □Y □N |
| | | | □Y □N |

How well does your child get along with his/her siblings?

_____
_____
_____

**Education**
Highest Grade/Degree Completed: _____ School: _____

School Concerns: Has the child ever had an IEP or 504 at any time? For what?

_____
_____
_____

Schools Attended:
Daycare / Pre-Kindergarten
Age(s)_____ Place_____
Elementary:
Age(s)_____ Place_____
Middle School:
Age(s)_____ Place_____
High School:
Age(s)_____ Place_____

Has the child ever repeated a grade? Yes No If yes, what grade(s) and why:

_____
_____

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Has the child ever been suspended/expelled/asked to leave / had attendance / tardiness from school/preschool? (explain)

_____
_____
_____

**Emotional/Behavioral**

Does your child have any history of /or suspected abuse or neglect or traumas (please explain):

_____
_____
_____

Please list 3 things your child does well (can be related to academics, social, behavior):

_____
_____
_____

How does your child typically behave when upset?

_____
_____
_____

Please describe your approach to discipline in your home. Please include if parents differ.

_____
_____
_____

Please check each disciplinary technique commonly used when the child behaves inappropriately:

☐Ignore problem behavior
☐ Reason with the child
☐Take away activity or food
☐ Scold child
☐Redirect interest
☐Spank child
☐ Threaten
☐Tell the child to sit on a chair
☐Send the child to their room
☐Use time out
    ☐Please explain length of time, place, etc.: _____

☐Other (Please explain): _____
_____

Which disciplinary actions are most effective?

_____

_____

Which disciplinary actions are least effective?

_____

_____

Which caregiver is usually responsible for administering discipline?

_____

_____

**Social Functioning**

Describe your child's social relationships (no friends, 1-2 close friends, many friends- no social problems, etc.)

_____

_____

Please indicate how the client relates to peers:

□ Has problems relating to other children
□ Has difficulty making friends
□ Fights frequently with peers
□Prefers playing with younger children
□ Prefers playing with older children
□Prefers to play alone
□ Has a best friend

What role does the client take in peer groups?

□Leader □Follower □Some of Each

**Technology/Screen Use (laptops, PC, cell phone, iPad, Kindle, etc.)**

Estimate how many hours/days the client spends on a screen After school hours: ____

Estimate how many hours/days the client spends online on the WEEKENDS: ____

Please specify their preferred types of usage: (Facebook, YouTube, gaming, texting, browsing, etc.): _____

_____

_____

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Do you feel technology use is balanced and healthy or could it use improvement? Please explain:

_____

_____

**Psychological and Psychiatric History**

Counseling and/or Psychotherapy Services (including individua, group, family/couples, parent training, etc.):

1. Name of Provider: _____
   Month/year(s) in treatment: _____
   Initial Reason for Therapy: _____
   Briefly describe whether it was helpful and how/why it ended:
   _____
   _____
   _____

2. Name of Provider: _____
   Month/year(s) in treatment: _____
   Initial Reason for Therapy: _____
   Briefly describe whether it was helpful and how/why it ended:
   _____
   _____
   _____

3. *USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.*

**Psychiatric Services**

Has the child ever been seen by a psychiatrist? If yes, who and has the psychiatrist given your child any mental health-related diagnosis or said one was suspected? Please include dates.

_____

_____

Has the child ever been hospitalized for psychiatric reasons? Please provide dates/ reasons for all. Please also include ER visits even if they were not kept overnight.

_____

_____

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**Family Psychiatric History**
Please check and identify any immediate or extended family members with a history of psychiatric difficulties.

| **Condition/Disorder** | **Who** | **Condition/Disorder** | **Who** |
|---|---|---|---|
| □ Abuse | | □ Bipolar Disorder | |
| □ Anxiety | | □ Depression | |
| □ ADHD/ADD | | □ Epilepsy/Seizure Disorder | |
| □ Autism Spectrum Disorder | | □ Genetic Condition | |
| □ Hospitalized for Emotional Problems | | □ Motor or Vocal Tics | |
| □ Intellectual disability | | □ Psychosis or Schizophrenia | |
| □ Jail Time/Incarceration | | □ Special Education | |
| □ Language disorder | | □ Substance Use | |
| □ Learning Disability | | □ Suicidal Ideation/Attempt | |
| **Other** | | | |

**Physical Health:**
Medical: Doctor(s) (name/phone):

_____

_____

_____

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Past/Present Medical (major medical problems, surgeries, accidents, hospitalizations, falls, illness, history of concussions, Lyme disease, etc.):

_____
_____
_____
_____

Medications the client is presently taking and for what. PRINT clearly:

_____
_____
_____
_____

**Legal Issues**

Are you involved in any lawsuit/s or divorce or custody dispute/s? (If you answer Yes, please explain). Please include any prior DCF cases (whether they are open or closed as unfounded)

_____
_____

Has 211 or 911 ever been called for the child? NO YES
Approximate Dates and Details:

_____
_____

What gives the client the most joy or pleasure in their life? Hobbies/ interests?

_____

What are the client's main worries and fears?

_____

What do you hope for your child to work on / improve while working with me (please include behaviors you are concerned about)?

_____
_____
_____
_____
_____

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Are there any race / culture / ethnicity / religious considerations you would like to share?

Is there any other information you would like us to know to help in our work with your child?

25 Church Hill Rd Suite 102 Newtown, CT 06470 203-689-7193 (o) 203-403-6131(f)

CENTER FOR ASSESSMENT AND PSYCHOTHERAPY

# CONSENT FOR TREATMENT OF MINORS

I _____ give my consent that Dr. Mary Murphy, PhD will be conducting psychotherapy with _____.

My relationship to the client is (parent, uncle, grandparent, etc.):
_____.

I was notified that all material discussed during the psychotherapy sessions is confidential and can only be released under specific circumstances such as times when a child is in danger of causing mortal harm to themselves, hurting others, or is at risk of or being hurt by others. I have been informed of the limitations to confidentiality in the HIPAA privacy form, which I have read and signed.

In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs, intimacy in relationships, etc. I will accept Dr. Mary Murphy's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

I have been informed that I am always allowed to and encouraged to provide information and or express concerns to Dr. Mary Murphy that I feel is important to share to aid in this minor's treatment via phone or email. I understand that Dr. Mary Murphy may not be able to reciprocate and provide details from this minor's treatment during these communications. I further promise not to communicate imminent concerns about the safety of my child and will instead notify emergency personnel if this occurs (e.g. 911, DCF, etc.).

I have been informed that there are times in which my child's confidential information may be shared with my office and clinical staff for the benefit of their treatment. Specifically, this includes discussion of client information during staff supervision meetings and care coordination amongst our clinical staff and interns.

I have been given the opportunity to ask and have any questions I have answered before signing this form.

| _____ | _____ | _____ |
|---|---|---|
| Name of Parent 1 (print) | Signature | Date |
| _____ | _____ | _____ |
| Name of Parent 2 (print) | Signature | Date |

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


# 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

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