Ashley Mullica, MSW, LCSW

Client Information

PLEASE COMPLETE & BRING TO YOUR FIRST SESSION
IF YOU ARE COMING IN FOR COUPLES THERAPY, BOTH PARTNERS NEED TO SEPARATELY COMPLETE AND SIGN THIS FORM

Name: _____
Last First Middle Initial

Date of Birth: _____/_____/_____
Month Day Year

Street: _____Unit_____

City, State, Zip: _____

	Confidential Voicemail		Message Can Be Left With Another Person	
Home Phone: _____	**Y**	**N**	**Y**	**N**
Cell Phone: _____	**Y**	**N**	**Y**	**N**
Work Phone: _____	**Y**	**N**	**Y**	**N**

Email Address: _____

Emergency Contact Name/Phone: _____

Alt. Emergency Contact Name/Phone: _____

How did you hear of this counseling practice? (check one):
___PsychologyToday.com
___GoodTherapy.com
___Insurance Company/Website
___Family member or friend
___Physician or other Healthcare Professional
___Other _____

Are you a private pay client or utilizing insurance? _____

Insurance Carrier: _____ ID:_____ Group #:_____

Main Subscriber Name: _____ Date of Birth: _____

187 Calle Magdalena, Ste 209 Encinitas, CA 92024 760-407-2827 ashleymullica@gmail.com

Ashley Mullica, MSW, LCSW

CLIENT RIGHTS

Any person who receives services for mental health, alcoholism, drug abuse or developmental disability is guaranteed certain rights. Among these rights are the following:

1. You must be treated with dignity and respect, free of any form of abuse.
2. You have the right to have your therapist make fair and reasonable decisions about your treatment.
3. You cannot be treated unfairly because of your race, national origin, sex, religion, age, disability or sexual orientation.
4. You must be provided prompt and adequate treatment and other services which are appropriate to your individual needs.
5. You must be allowed to participate in the planning of your treatment.
6. You have the right to discuss positive and negative effects of your treatment and to discuss alternative treatments with your therapist.
7. No treatment may be given without your consent except in an emergency.
8. You have the right to know the cost of your treatment and to discuss these costs with your therapist.
9. You will not be filmed or taped without your written permission.
10. Information regarding your treatment must be kept confidential unless you have released them.
11. Your records cannot be released without your signed authorization, except in other instances as outlined by HIPAA (See HIPAA Notice of Privacy Practices).
12. You have the right to see your records and to discuss them with your therapist.
13. You may challenge the accuracy of your records and have corrections placed into the record.
14. If you feel your rights have been violated, you may file a grievance. The grievance policy is outlined under the policies section.

I have read and understand these rights.

_____

CLIENT SIGNATURE **DATE**

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Ashley Mullica, MSW, LCSW

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read, understand, and have been provided a copy (via website or hard copy) of Ashley Mullica, MSW, LCSW's privacy policies regarding the protection of my health information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____

CLIENT SIGNATURE **DATE**

AUTHORIZATION FOR CONTACT BY TELEPHONE/VERBALLY IN EVENT OF BREACH OF PHI

I authorize Ashley Mullica, MSW, LCSW to provide notice to me by telephone or verbally in the event of a breach of my Protected Health Information (PHI) by Ashley Mullica, MSW, LCSW. Such conversation shall be documented by Ashley Mullica, MSW, LCSW.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Ashley Mullica, MSW, LCSW.

_____

CLIENT SIGNATURE **DATE**

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Ashley Mullica, MSW, LCSW

INFORMED CONSENT TO TREATMENT

Psychotherapy is a process designed to help people learn to function better and feel better in their daily lives. People seek therapy to change emotional, interpersonal or behavioral issues. In many instances people who do not receive treatment for emotional problems report that their distress increases and this can lead to a significant disruption in mental, interpersonal and physical functioning. Initially, many people report feeling an increase in distress as they come to grips with important issues. Through therapy, people oftentimes make changes in personal coping strategies, careers or relationships. These changes can be distressing to the individual, to family members and to friends. It is important that you understand the risks and implications of beginning therapy, discontinuing therapy or changing your treatment plan. Your specific situation is unique and will be discussed in detail with your therapist.

I realize that my initial treatment plan should be developed with my therapist and approved by me. My treatment plan will evolve as my needs change and each change should also be discussed and approved by me. I understand that my therapist and I will review my treatment plan at least annually. I understand that my therapist and I should regularly discuss the implications of my continuing in therapy, adjusting the modality of therapy, seeking alternative treatment, and the implications of terminating therapy. I also understand that it is my right to make any of these decisions. I further understand that my therapist is responsible to provide therapy which she believes to be effective and appropriate to my needs. I am also aware if guidance is needed, my therapist may consult with another therapist (client name and other identifying information will not be shared). I understand that any communication via cell phone or email may be heard or read by a third party, as these are not secure forms of communication. Therefore, I understand that my therapist does not communicate clinical information over email, text, or other electronic means and prefers to discuss clinical information or concerns only in-person or over the phone.

For parents/guardians of children: I attest that I have the legal right to consent to treatment for this child.

I hereby consent to begin therapy.

_____

CLIENT NAME (PRINT)

_____

CLIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

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Ashley Mullica, MSW, LCSW

Policies of Ashley Mullica, MSW, LCSW

Billing, Payment and Insurance

My billable rates are as follows:

- Initial 60 minute psychotherapy session/assessment……..$125
- Subsequent 60 minute psychotherapy session……..$110
- Subsequent 90 minute psychotherapy session……..$150

Other session times are available upon request.

Report writing, consultations with other health care providers (at the request of the client) or telephone contacts with clients lasting over 5 minutes are charged at the same pro-rated hourly cost.

Copies of records, if requested, are charged at $.50 per page plus administrative costs such as time.

I offer a sliding fee scale for some hardship cases. Please consult with me to discuss your specific situation.

I am in network with a few insurance companies and will bill your insurance for services provided. However, I am still an out-of-network provider for any other insurance companies. In addition, therapy sessions are covered 100% by employment flex spending and health spending accounts and I accept FSA and HSA cards for payment. In addition, many PPO's will provide coverage for out of network mental health treatment. If requested, I will provide you with a SuperBill (summary statement of charges and payments received) which you can submit directly to your insurance provider with any other forms they require to be reimbursed directly by them. I cannot guarantee reimbursement by your insurance company. If you are looking to be reimbursed by your insurance provider with an out of network mental health provider it is very important you call them prior to starting therapy to find out exactly what mental health services are covered and the reimbursement amount.

Clients are responsible for full payment of services at the time of service. If outstanding money is owed, you will receive a bill at the end of the month. Accepted forms of payment include: cash, personal check, FSA/HSA cards, credit card (Visa, MasterCard, Discover or American Express) and PayPal. If you choose to pay with PayPal, payment is required prior to our appointment. If you have more than one unpaid session, I reserve the right to suspend services until your account is paid in full. In accordance with HIPAA, I have the right to release any pertinent treatment information via paper or electronic means to obtain payment for services.

If you do not bring payment to each session in the form of cash or check, it is a requirement that a current credit card is on file. If you overpay on your account, you will be reimbursed with the amount that you overpaid. If your account is not in good financial standing, you may be referred to another provider. If you default on your payments and 60 days has passed without payment arrangements, collection or court-related action may be taken against you. In that case, you are liable for collection or court-related costs. An account is considered past due if full payment has not been received after 30 days of the receipt of your bill. I am happy to answer any questions you have about billing and payment. It is best to discuss any concerns/questions immediately so that financial matters do not interfere with your therapy.

No Shows/Late Cancellations

I have a 24 hour notice cancellation policy with the exception of emergency situations that will be handled on a case by case basis. If you cancel an appointment without 24 hours' notice you will be charged a $50 late cancellation fee. If you no show a scheduled appointment you will be responsible for the full session fee

and will be billed accordingly. I cannot bill insurance for missed appointments. Because of the nature of private practice, and the amount of time we schedule for an appointment, that time is viewed as a contract between the therapist and client. When late cancellations or no-shows occur, that time cannot be given to another client who may be in need of services. Please do not cancel appointments via email as your email may not be read in time if I am in session. If you cancel and/or no-show for two consecutive appointments and/or if you haven't been seen for 30 days without a future appointment scheduled, you may be considered an inactive client and may be discharged.

Confidentiality

All of our sessions are strictly confidential. My professional code of ethics prevents me from discussing what is said during sessions with anyone other than therapy participants, or from releasing any records without the written permission of my client(s). The only exceptions to this are if someone is in danger of being harmed (i.e. abuse of a child, elder or other vulnerable adult), there is an immediate and serious threat to your own or someone else's health and safety, or if the law explicitly states that confidentiality provisions do not apply in a particular case. I may, in certain cases, consult with a colleague if I feel that I may need guidance or another opinion; in such cases, the names or identifying information of clients will not be shared. If therapy involves the participation of a partner or spouse, I do not guarantee confidentiality among therapy participants. In these cases, I will, however, use my professional discretion in deciding whether to disclose communications relayed to me. I do not connect with clients via social media (i.e. LinkedIn, Facebook, etc.) in order to protect client confidentiality. If I see clients in public, in order to maintain confidentiality I do not initiate contact or conversation with them. In those situations, it is up to the client(s) if they wish to acknowledge or greet me, but regardless, neither the nature nor details of the therapeutic relationship will be discussed by me.

Confidentiality in Couple's Therapy

I do not keep secrets from those participating in couple's therapy. If you and your partner decide to have some individual sessions as part of couple's therapy, please note what you say in those individual sessions will be considered to be a part of couple's therapy, and can be discussed in the joint session. Do not tell me anything you wish to keep a secret from your partner.

When I provide couple's therapy, I consider my client to be the couple. As a result, I will not release information or assessments about the couple or their therapy without the consent of both members of the couple.

In order for couple's therapy to be effective, you are agreeing not to call on Ashley Mullica to testify in any court hearing regarding custody, divorce/separation proceedings, or financial settlements with a spouse. This would undermine therapy. As well you are agreeing not to use the information shared in couple's therapy, emails or in correspondence in any court proceeding or custody evaluation.

Litigation Limitation

It is agreed that neither the client nor his/her attorney shall call upon me to testify in any legal proceeding (such as child custody disputes, divorce proceedings, etc.). The client expresses understanding that I do not specialize in custody evaluations or other forms of legal testimony. If you are seeking any legal testimony, I am able to provide an appropriate referral or recommendation to a specialist in this area.

Children and Adolescents

Any person under the age of 18 who is not emancipated needs parental consent for treatment. I will request parents be involved in the beginning stages of therapy to obtain their input as to the nature of the problem, etc. Parent involvement is often based on the age of the child and parents can expect to be more involved the younger the child is and less involved if the child is of adolescent age. Periodic updates from parents are appreciated throughout therapy as it provides additional information regarding the child/adolescent's progress. However, during therapy, sensitive issues are often discussed and it is

therefore recommended that therapy be viewed as confidential between the child and therapist. Specific information shared during sessions should be kept confidential so that the child or adolescent feels safe discussing these issues. It is oftentimes beneficial for other family members to participate in some sessions, and this will be done with the permission of the primary client (child or adolescent). If there is a threat of harm or danger to the child, parents will be notified.

Please note in cases of divorce/separation, Ashley Mullica, is not trained in court custody evaluations. By signing this you are agreeing not to call on Ashley Mullica to testify in any court hearing regarding custody or divorce/separation proceedings. You are also agreeing not to use the information provided by Ashley Mullica regarding your child's therapy, emails or in correspondence in any court proceeding or custody evaluation. You are also agreeing to sign a safe harbor agreement that addresses this issue in more detail.

Emergency Services

In the case of a mental health emergency, please report to the nearest hospital emergency room, dial 911, or contact the San Diego County Crisis Line 1-888-724-7240. Please also contact me and request an emergency appointment if possible. Please note, however, that my office phone number is not an emergency number. Please do not send requests for urgent appointments via email.

Records

Records are maintained according to state law and HIPAA. You are entitled to a copy of your records by submitting a request in writing. Please contact me with any questions pertaining to records. Professional psychotherapy records can be confusing or misinterpreted and it is therefore recommended to first request a records review with me or have the records sent to another professional who can help you interpret them. In the event of practice closing or death of practitioner, records will be forwarded to and maintained by another licensed mental health practitioner for their duration per state law.

Referral Services

I am not a physician and therefore cannot prescribe medication. If a medical evaluation is warranted, I am happy to provide you with an appropriate referral. If you require more intensive care, such as day treatment or inpatient care, a referral can be made to a facility that can accommodate your needs.

Grievance Policy

If you are unhappy with the services you are receiving, it is first best to talk with me so that I may respond to your concerns directly. Such concerns will be taken seriously and met with care and respect. If you believe that appropriate resolution has not been attained, you may file a formal grievance with me in writing within 45 days of the time you become aware of the problem. I will investigate your grievance and attempt to resolve it. Unless the grievance is resolved informally, I will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report. If you and I agree with the report and recommendations, the recommendations shall be put into effect within an agreed upon time frame. If you are not happy with my report and recommendations, you may request mediation with a neutral party mutually agreed upon by both therapist and client. The cost of such mediation will be split equally between therapist and client, unless otherwise agreed upon. If mediation is unsuccessful, arbitration can be settled in San Diego County in accordance with the rules of the American Arbitration Association. You may also contact the California Board of Behavioral Sciences at www.bbs.ca.gov to file a formal license complaint or take the matter to court if you believe your rights have been violated. No adverse action will be taken against you if you file a grievance.

I agree to the aforementioned policies.

_____

CLIENT SIGNATURE **DATE**

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Ashley Mullica, MSW, LCSW

Credit Card Authorization

Please note: *It is requested that all clients have a credit card on file. The credit card payment option is offered as a convenience to clients. The credit card will not be charged without your consent unless you have marked authorization to charge your credit card anytime you owe money for services.*

CREDIT CARD AUTHORIZATION

I authorize Ashley Mullica, MSW, LCSW to keep my credit card on file and/or to charge my credit card for (check one):

_____ Anytime I owe Ashley Mullica, MSW, LCSW money for services.
(Your credit card will be charged for the full balance due.)

_____ Other amount: $_____(one time charge)

_____ On file only. (See credit card policy statement above).

Credit Card Information

Client/Patient Name: _____

Cardholder Name: _____

Credit Card Type: ___VISA ___MasterCard ___Discover ___American Express

Account Number: _____-_____-_____-_____ CVV: _____

Expiration Date: _____ / _____
Month Year

Card Billing Address: _____
Street Unit

City State Zip

_____
CARDHOLDER SIGNATURE DATE

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