Advancing Inspired Minds

Marcia J. McKinley, JD, PhD, NCC, LCPC (Maryland), LPC (Virginia), DCC
512 Herndon Parkway, Suite F * Herndon, VA 20170
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www.DrMarciaJMcKinley.com

For My New Clients,

I look forward to meeting and working with you.

Often initial sessions of psychotherapy are filled with doing paperwork and don't provide the therapist and client much time to get to know each other. Because therapeutic rapport is the single most important factor in helping the client reach his or her goals, I would like to move beyond paperwork as quickly as possible.

Toward that end, I am enclosing the necessary paperwork here. Specifically, you will find the following

* **Client Contact Form** (so that I know how to be in touch with you)

* **New Client Information Form** (requested from my billing provider)

* **Credit Card Authorization Form** (to complete if you are planning to pay by credit or debit card; we can fill the amounts in once I have determined your insurance benefits; please bring your insurance card and driver's license to your first session)

* **Informed Consent** (which we will also review at our first session)

* **HIPAA Notification of Privacy Policies** (which you may keep)

* **Acknowledgement of Receipt of HIPAA's Notification of Privacy Policies**

* **Release of Information Forms** (optional; you should complete one for each person—parent, teacher, principal, general practitioner, psychiatrist, etc.—with whom you would like me to exchange information; if you are unsure about

which options to choose, just fill out the other professional's information at the top of the form and we can discuss the other options together)

* **Adult Psychosocial History Form** (to complete if you are an adult)

* **Child/Adolescent Psychosocial History Form** (to complete for your child, even if your child is currently over 18 years of age, in which case s/he should complete the Adult Form and you can complete the Child/Adolescent Form, skipping any parts that are duplicative)

I look forward to meeting you soon.

Best,

Marcia

Marcia J. McKinley, JD, PhD, NCC, LCPC (Maryland), LPC (Virginia)

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CLIENT CONTACT FORM

Client Name:_____

Client's DOB: _____

Client's Address:_____

Client's Email Address:_____

Client's Phone Numbers: home_____ **work**_____
cell_____ **(please star the best # to reach you)**

Name of Person Completing This Form:_____

Emergency Contact Name: _____

Emergency Contact Email Address: _____

Emergency Contact Phone Numbers:
home_____
work_____
cell_____ **(please star the best # to reach you)**

If the client is under the age of 16, do I have your permission to
Call him/her? If so, at what number?_____
Text him/her? If so, at what number? _____

May I include you on my mailing list (which is never shared with anyone but includes announcements for local events of interests and new blog posts)? Yes No

How *may* I contact you? How do you *prefer* to be contacted?

_____ **Email (when sent from my NeoCertified account, it is encrypted; your response to my NeoCertified account is also encrypted)**
_____ **Phone**
_____ **Text**

Marcia J. McKinley, JD, PhD, LCPC

New Client Information Form

Personal Information (All areas marked with a * MUST be completed)

*Client's Legal Name: _____ Nickname: _____
First *MI* *Last*

*Client's Home Address:

_____
Street *City* *State* *Zip*

*Client's E-mail Address: _____@_____

Client's Home Phone #: (_____)_____

Client's Business Phone #: (_____)_____

*Client's Main Cell Phone #: (_____)_____

Other Important Phone #: (_____)____ _____ *Type of # ?: _____

*Client's Date of Birth: _____ /_____ /_____ Age: _____

*Client's Gender (circle one): Female Male

*Client's Marital Status (circle one): Single Married Other (Other includes Divorced, Widowed & Domestic Partnerships)

*Client's School *OR* Work Status (circle only one):F/T Student P/T Student *OR* Employed Not Employed

Primary Insurance Information (All areas marked with a * MUST be completed)

*Insurance Company Name: _____

Insurance Company Phone #: (_____)_____

*Subscriber's Name (if different): _____

*Subscriber's Date of Birth: _____ /_____ /_____ *Relationship to Client: _____

*Subscriber's Employer: _____

*Subscriber's Insurance ID#: _____

*Subscriber's Group Policy/ID #: _____

*Subscriber's Phone # (if different): (_____)_____

*Subscriber's Address (if different):

_____
Street City State Zip

*Co-Payment Amount (Payment is required at appointment time): $_____

*Does the Client have an "Out-of-pocket deductible" for counseling? (circle one): Yes No

*Does the Client require a "Pre-Authorization" before counseling begins?(circle one): Yes No

Pre-Authorization Code (Provided by subscriber's insurance company): _____

Marcia J. McKinley, JD, PhD, LCPC

New Client Information Form

Family Information (All areas marked with a * MUST be completed)

Immediate Family Members :

*Spouse's Name: _____ Age: _____
First MI Last

Spouse's Employer: _____

Spouse's Business Phone #: (_____) _____

*Children/Siblings (First names & ages only):

_____ _____

_____ _____

*Other Extended Family Members Living With Client:

Name: _____ *Relationship to Client: _____

Name: _____ *Relationship to Client: _____

Emergency Contact Information (All areas marked with a * MUST be completed)

*Name: _____ *Relationship to Client: _____

*Contact Phone #1: (_____) _____

*Contact Phone #2: (_____) _____

*Emergency Address:

_____
Street City State Zip

Secondary Insurance Information (All areas marked with a * MUST be completed)

*Insurance Company Name: _____

Insurance Company Phone #: (_____) _____

*Subscriber's Name (if different): _____

*Subscriber's Date of Birth: _____ /_____ /_____ *Relationship to Client: _____

*Subscriber's Employer: _____

*Subscriber's Insurance ID#: _____

*Subscriber's Group Policy/ID #: _____

*Subscriber's Phone # (if different): (_____) _____

*Subscriber's Address (if different):

_____
Street City State Zip

Marcia J. McKinley, JD, PhD, LCPC

New Client Information Form

Mental Health Information (All areas marked with a * MUST be completed)

*Reason(s) for seeking counseling (circle all that apply):

ADD/ADHD
Anger
Anxiety
Children
Chronic Pain
Compulsions
Couple/Marital
Depression
Employment
Family
Gender
Grief/Bereavement
Medically Related
Obsessions
Panic Attacks
Phobias
Self Harm
Sexuality
Stress
Substance Abuse

Other Issues (please specify): _____

*How long ago did the Client first experience the issue they are seeking counseling for?: _____

*Periods of prior counseling and/or psychiatric hospitalizations (if applicable): _____

*Prescribed Mental Health Medications:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Physical Health Information (All areas marked with a * MUST be completed)

*Does the Client have a Primary Care Physician(circle one): Yes No

*Primary Care Physician's Name: _____

*Primary Care Physician's Phone #: (_____)_____

*Is the Client currently experiencing any chronic physical issues or limitations (circle one): Yes No

Briefly explain any physical issues: _____

*Does the Client smoke or use tobacco products?(circle one): Yes No How much per day?: _____

*Does the Client drink alcohol regularly?(circle one): Yes No How many drinks per day?: _____

*Prescribed Physical Health Medications:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

*I hereby certify that the subscriber listed in this document has active behavioral health coverage with _____ Insurance Company. My signature below is providing express consent to assign all insurance benefits from this company, in relationship to this treatment, otherwise payable to me, directly to _____.

I further understand that if the subscriber's behavioral health coverage is denied or terminated during the course of treatment, I am completely responsible for all payments of any services rendered. This includes co-payments and deductibles that are not reimbursed through the subscriber's insurance policy. I hereby authorize _____ to release all information necessary to secure the payment of benefits. I authorize the use of the signature below on all insurance submissions, whether manually or electronically.

*Client (or guardian) signature: _____ Date: _____

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MD License #LC5264 * VA License #0701007349 * NPI #1336534007 * EIN #81-4806419

Credit Card Authorization Form

By signing below, I authorize Dr. Marcia J. McKinley to charge my credit card for any services not paid for at the time services were rendered, as follows:

Initial to Agree	Charge and Service
	$_____ per 45-minute session
	$_____ per 60-minute session
	$_____ per 90-minute session
	$_____ owed on account balance
	$_____ for other agreed-upon services such as extended phone calls, collateral consultation, etc.
	$_____ cancellation fee (without 48 hours notice)*

Name on Card:_____
Type of Card (circle): AMEX Discover MC Visa
Is this an HSA or FSA card? (circle) Yes No
Card # _____
Exp. date _____ Security code (last 3 digits on back of card) _____
Zip code associated with card: _____

Signature _____

**Clients are charged a $50 cancellation fee for a 45- or 60-minute appointment not cancelled 48 hours in advance, or $100 for a 90-minute appointment not cancelled 48 hours in advance.*

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Informed Consent for Treatment

Welcome to Advancing Inspired Minds (AIM) and the counseling practice of Marcia McKinley, JD, PhD, NCC, LCPC. The helpfulness of a therapeutic relationship is largely determined by the therapeutic bond between the client and counselor. This document is intended to help strengthen the therapeutic bond by laying out my professional services and business practices. Our signatures on this document represent an agreement between us. You may revoke this agreement in writing at any time. In addition, the Health Insurance Portability and Accountability Act (HIPAA), a Federal law, requires that I provide you with a Notice of Privacy Practices and that I obtain your signature acknowledging that I have provided you with this information. Those Privacy Practices appear in a separate document and constitute a part of this agreement.

My Responsibilities to Clients

1. Confidentiality

You have the right to complete confidentiality in your therapy. Any information obtained in the counseling session or in written form will not be disclosed to any outside person(s) or agency without your written permission except in situations defined below.

a. If you and your partner decide to include individual sessions as part of couple's therapy, what you say in those individual sessions will be considered to be a part of the couple's therapy, and can possibly be discussed in our joint sessions.

b. If you want your insurance to pay for all or part of your treatment, I must be able to discuss your diagnosis and treatment with their representative.

c. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency.

d. If I believe that it's imminent that you will harm another person, I will attempt to inform that person and warn them of your intentions. I will also contact the police and tell them of my concerns.

e. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must call Child Protective Services or Adult Protective Services immediately.

f. If I believe that you are in imminent danger of harming yourself, I may call the police or the county crisis team. I will explore other options with you before taking this step.

g. If you tell me of another mental health care provider that has engaged in sexual contact with a client or is impaired emotionally or behaviorally, I am required to report the information to the licensing board of the provider. I would inform you before taking this step.

h. If I am issued a subpoena to testify in court and/or to release written records, I may be required to do so.

In addition, coordination of care amongst treating professionals is important and I encourage you to sign Release of Information forms that would allow me to communicate with your primary care physician, psychiatrist, and other treating professionals.

2. Electronic Communication

It is important to understand that communication through e-mails may not ensure confidentially; emails can be saved on computer hard drives and servers. To reduce the risks to my clients, it is my practice to use my professional gmail account (DrMarciaJMcKinley@gmail.com) only to confirm appointments. If we need to communicate about more substantive matters, we can use an email from my NeoCertified account. Anything that I send to you via this encrypted system will be encrypted; anything that you send back in response will also be encrypted.

Despite these precautions, I cannot guarantee the privacy of any of our communications via text or email. If you **do not wish to use texts or e-mails to communicate, please inform me of this fact.**

I recognize that social networking has become more commonplace. To ensure confidentiality for both of us, I will not connect to you on any social-networking sites.

3. Record-Keeping

I keep two sets of records: one set contains records of the dates of service, payment due, and payments made. The other set contains appropriate records of the psychological services that

I provide. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a general mention of the topics discussed. You have the right to a copy of both sets of records at any time. You have the right to request that a copy of either of your files be made available to any other health care provider at your written request. Your records are maintained in a secure location.

4. Diagnosis

You should be aware that insurance companies, or other third parties responsible for paying your bill, will require you to authorize me to provide them with a clinical diagnosis. Diagnoses are technical terms that describe the nature of your problems and whether they are short or long term. All diagnoses come from a system called the ICD-10. If I assign a diagnosis, I will discuss it with you and, if you have questions, make resource materials available to you.

5. Other Rights

The counseling relationship is established between you and I to work on areas that have been or will be identified to require attention. I do not accept clients that I do not believe I can help. Accordingly, I am very optimistic about progress. To better serve you I would like to maintain a steady commitment to our counseling sessions. Meetings are purely voluntary, and you may terminate future therapy sessions at any time. However, termination is itself an important part of therapy process; thus, I request that you provide notice of your expected termination of services. If I believe that I can no longer provide appropriate care, I will offer you referrals to other sources of care. I cannot guarantee that those sources will accept new patients but I will make every attempt to find future help.

6. Disputes and Complaints

If at any time during the course of your treatment here, you become unhappy with what is happening in therapy please feel free to address these concerns with me. If you feel that I cannot listen or respond or that I have behaved unethically, you can contact the Maryland Board of Professional Counselors and Therapists at 4201 Patterson Ave., Baltimore, MD 21215 Attn: Karen Wamsley, Health Occupational Investigator or online at wamsleyk@dhmh.state.md.us. In Virginia, you can contact the Virginia Board of Professional Counselors at Perimeter Center, 9960 Mayland Drive, Suite 300, Henrico Virginia 23233-1463 or by phone at (800) 533-1560.

Please initial and date here to indicate your understanding of and agreement to my responsibilities to you: _____

Training and Approach to Therapy

1. Background

I earned a bachelor's of psychology at George Mason University, a law degree from the University of Southern California, a PhD in Psychology (specialties in Cognitive and Developmental Psychology) from George Mason University, and a MS in Pastoral Counseling from Loyola University Maryland. In addition, I have completed training in neurofeedback under the supervision of Joan Ordmandy of BiofeedbackWORKS in VA and in EMDR under the supervision of Rachel Harrison, LCPC. My professional license with the Maryland Board of Professional Counselors and Therapists (at 4201 Patterson Ave., Baltimore, MD 21215) is # LC5264 and my professional license with the Virginia Board of Counseling is #0701007349.

I am trained to provide services to individuals who are experiencing mood or anxiety issues, who are highly sensitive and/or gifted, who have identity and self-esteem issues, and who are facing major life adjustments (including changes in relationships, careers, or educational settings). I draw from a variety of traditions in my work with clients, including coaching, humanistic therapy, rational-emotive behavioral therapy, insight-oriented modalities, and narrative techniques. In addition, my training in developmental psychology and make me especially attuned to developmental tasks, the variables that impact such tasks, and the impact that such tasks have on later development. If you ever have any questions about what we are doing in therapy, I hope that you will speak to me about it.

I try to return communication from clients within 24 hours, usually at the end of a day. If you are having an emergency that cannot wait until the end of the day, please contact your primary care physician or call 911. If I am aware that I will be unavailable due to vacation or personal emergency, I may ask another licensed mental-health professional to assume my therapeutic responsibilities during my absence; we will discuss such occurrences as they arise.

2. Supervisory Relationships

I regularly consult with several experts in the field in order to ensure you with the best possible care. In all correspondence with such consultants, you will not be identified by name or by any information which could personally identify you, unless you have previously signed a confidentiality release form. Furthermore, any consultants are also legally bound to maintain confidentiality.

3. *ACA Code of Ethics*

I am a member of the American Counseling Association and am bound by the code of ethics of this organization.

4. Developmental and Cultural Sensitivities

The *ACA Code of Ethics* emphasizes the need to communicate in ways that are developmentally and culturally appropriate and encourages counselors in collaboration with clients to make adjustments to counseling methods and informed consent in the context of cultural differences. As an ACA member, I celebrate diversity and embrace a cross cultural approach in counseling in support of the potential, uniqueness, and the dignity of each individual within their social, developmental and cultural contexts.

5. No Guarantees

There can be many goals for the counseling relationship. Some of these will be long-term goals such as improving the quality of your life, learning more about yourself, and self-actualizing. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, or changing behavior. You will set the goals for therapy. I may make suggestions on how to reach those goals but you decide where you want to go. Although I will do my best to give you best quality care for any goals we define, I cannot guarantee that those goals will be met. In marital counseling, I cannot guarantee that marriages will not terminate.

6. Risks and Benefits

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Progress may be slow, and clients can sometimes make improvements only to go backwards after a time. Sometimes major life decisions are made, which is a legitimate outcome of the counseling experience resulting from an individual calling into question many of their perspectives and priorities. I will be available to discuss any of your assumptions or possible negative side effects in our work together.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and offer many other advantages. We will explore your goals for therapy early in our work together.

Please initial here to indicate your understanding of and agreement to Dr. McKinley's background and approach to therapy: _____

Clients' Responsibilities

1. Involvement

For therapy to be most effective, it is important that you take an active role in our meetings. You must be present for your scheduled sessions, which I normally schedule at 1-week intervals, and you must work on things we discuss outside of sessions.

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I am doing, and to look at alternatives that might work better. You are responsible for coming to your session on time and at the time we have scheduled. If you are late to our session, I will end at the anticipated time and will not run over projected end time. If I am late to our session, we will extend the session if possible or we will make other arrangements by mutual consent.

If you do not schedule another appointment with me within 1 month of our last session, I will assume that you have decided to discontinue treatment with me and will close your file, unless you have informed me otherwise. Please be assured that you are always welcome to return regardless of how much time has lapsed since our last session.

2. Cancellation Policy

Because I will be reserving a time slot for you that I cannot offer to anyone else, you will be charged for all missed appointments and cancellations of less than 48 hours. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires), or if you or someone for whom you are a caregiver you are has fallen ill suddenly.

The cancellation fee for a 45-or 60-minute session is $50; the fee for a 90-minute session, as is sometimes required for couples counseling, is $100. I will ask you to keep an active credit card on file with me so that I can charge you for missed sessions.

3. Fee Schedule

My out-of-pocket fee schedule is as follows:

(1st session; 70-80 minutes)	$180.00
Regular sessions (38-52 minutes):	$120.00
Extended sessions (53-60 minutes):	$150.00
Group sessions	depends on group

Emergency phone calls of less than ten minutes are normally free. However, if I spend more than 10 minutes in a week on the phone, if you leave more than ten minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to documents

or emails from you (or to another provider) during a given week, I will bill you on a prorated basis for that time (at $120/hour). Such time is normally not reimbursable by insurance.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including time spent in preparation, transportation, and waiting, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $400 per hour for any tasks associated with such involvement, including but not limited to communication with attorneys, preparation for, travel time to, and attendance at any legal proceeding.

My fee goes up $10.00 every 2 years. If a fee raise is approaching, I will remind you of this well in advance.

4. Payment Policies

I am paneled with several insurance companies. If you plan to use insurance to cover your costs, please provide me with your insurance information, driver's license, and the name/relationship of the policyholder so that I can verify your insurance benefits before your first session.

I ask that at each session you pay your co-pay; co-insurance; or, in the event you have not met your deductible, the full contracted fee until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, you must pay the balance due during the following session. If your balance exceeds $250.00 we will need to ask that you pay for services when rendered. We ask that every client authorize payment of medical benefits directly to Advancing Inspired Minds.

I accept cash, check, VISA, Mastercard, and Discover. I do not accept barter for therapy, accept Paypal, or participate with Medicare. Any overdue bills will be charged 1.5% per month interest. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to an attorney or collection agency.

Please initial here to indicate your understanding of and agreement to your responsibilities as a client: _____

Client Consent to Psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fees outlined above. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake services with Dr. Marcia McKinley. I know I can end therapy at any time I wish.

I am over the age of eighteen or, if I am not over the age of eighteen, I understand that my parent/guardian will also sign to consent to treatment.

Client's Signature and Date:_____

Client's Printed Name:_____

Therapist's Signature:_____

If the client is under 18 years of age:

Parent or Guardian's Signature and Date:_____

Parent or Guardian's Printed Name:_____

Therapist's Signature:_____

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HIPAA Notice: Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with

your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

- **To Treat you**
  We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues**
  We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety.

- **Do research**
  We can use or share your information for health research.

- **Comply with the law**
  We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

- **Respond to organ and tissue donation requests**
  We can share health information about you with organ procurement organizations.

- **Work with a medical examiner or funeral director**
  We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

- **Address workers' compensation, law enforcement, and other government requests**
  We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services.

- **Respond to lawsuits and legal actions**
  We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- This notice is effective 1/1/2018
- If you have questions or concerns about this notice, you may contact the Privacy Official, Dr. Marcia J. McKinley at 703-713-2442 or DrMarciaJMcKinley@gmail.com .
- AIM will never market or sell personal information.

State Laws

Many states have laws that modify or clarify the Federal HIPAA laws. Those state laws are available from AIM on request.

Advancing Inspired Minds

Marcia J. McKinley, JD, PhD, NCC, LCPC (Maryland), LPC (Virginia), DCC
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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of AIM's Notice of Privacy Practices effective 12/31/2016.

Name (please print): _____
Signature: _____
Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of AIM's Notice of Privacy Practices effective 12/31/2016.

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective 12/31/16 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

- ☐ In person conversation _____
- ☐ Telephone contact _____
- ☐ Mailing _____
- ☐ Email _____
- ☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE PROTECTED INFORMATION

Client Name_____ **DOB**_____

I AUTHORIZE DR. MCKINLEY TO:

_____Release information to _____Obtain information from _____Discuss information with

Name_____
Address_____
City, State, and Zip_____
Phone_____
Email_____ Fax_____

Purpose of Disclosure:
_____Coordination of care _____Other:_____

Type of Information To Be Released:

_____Intake notes
_____Medical history
_____Psychosocial history
_____Assessment and diagnosis
_____School records/information
_____Legal records/information
_____Medication and treatment records
_____Summary of psychological testing
_____Discharge or closing summary
_____Progress notes
_____Treatment plans
_____Substance use & treatment
_____Oral discussion of any information relating to diagnosis or treatment

This Authorization:
_____Expires 1 year after date of signature below _____Expires (date)_____
_____Does not expire during period of active service, unless specified in writing
_____Does not expire until 5 years after termination of service (at which point records are destroyed)

I understand that I may revoke this authorization, in writing, at any time.

_____	_____	_____
Client's Signature	*Client's Printed Name*	*Date*
_____	_____	_____
Signature of Parent/Guardian	*Printed Name of Parent/Guardian*	*Date*
_____	_____	_____
Therapist's Signature	*Therapist's Printed Name*	*Date*

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AUTHORIZATION TO RELEASE PROTECTED INFORMATION

Client Name_____ **DOB**_____

I AUTHORIZE DR. MCKINLEY TO:

_____Release information to _____Obtain information from _____Discuss information with
Name_____
Address_____
City, State, and Zip_____
Phone_____
Email_____ Fax_____

Purpose of Disclosure:
_____Coordination of care _____Other:_____

Type of Information To Be Released:
_____Intake notes
_____Medical history
_____Psychosocial history
_____Assessment and diagnosis
_____School records/information
_____Legal records/information
_____Medication and treatment records
_____Summary of psychological testing
_____Discharge or closing summary
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I understand that I may revoke this authorization, in writing, at any time.

_____	_____	_____
Client's Signature	*Client's Printed Name*	*Date*
_____	_____	_____
Signature of Parent/Guardian	*Printed Name of Parent/Guardian*	*Date*
_____	_____	_____
Therapist's Signature	*Therapist's Printed Name*	*Date*

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AUTHORIZATION TO RELEASE PROTECTED INFORMATION

Client Name_____ **DOB**_____

I AUTHORIZE DR. MCKINLEY TO:

_____Release information to _____Obtain information from _____Discuss information with

Name_____
Address_____
City, State, and Zip_____
Phone_____
Email_____ Fax_____

Purpose of Disclosure:

_____Coordination of care _____Other:_____

Type of Information To Be Released:

_____Intake notes
_____Medical history
_____Psychosocial history
_____Assessment and diagnosis
_____School records/information
_____Legal records/information
_____Medication and treatment records
_____Summary of psychological testing
_____Discharge or closing summary
_____Progress notes
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_____Substance use & treatment
_____Oral discussion of any information relating to diagnosis or treatment

This Authorization:

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_____Does not expire until 5 years after termination of service (at which point records are destroyed)

I understand that I may revoke this authorization, in writing, at any time.

_____	_____	_____
Client's Signature	*Client's Printed Name*	*Date*
_____	_____	_____
Signature of Parent/Guardian	*Printed Name of Parent/Guardian*	*Date*
_____	_____	_____
Therapist's Signature	*Therapist's Printed Name*	*Date*

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CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY FORM

Name of Person Completing This Form:_____
Relationship of This Person To Child/Teen:_____ _____
Date Completed:_____

Identifying Information

Client Name: _____

Date of Birth: _____

Circle One: Male Female Other (please specify):_____

It is very important to your child's success that your coach understands as much about your child as possible. Please answer the questions as honestly as you can, and feel free to explain or add any other information. If a question does not apply to you or your situation, please write N/A. This information, like all other information you provide, is confidential.

Presenting Problems

1. Has your child been diagnosed with any mental health disorders (e.g., ADHD, generalized anxiety disorder, etc.)? If so, by whom and using which tests? (If you are providing copies of a test, reference that here.)_____
_____
_____
_____
_____
_____

2. What *symptoms* (e.g., poor organization, excessive worries, fidgetiness, etc.) have led you to seek testing/coaching at this time? _____

3. For how long have you observed symptoms of these conditions? _____

4. How do these symptoms impacted your child's home life?

5. How have these symptoms impacted your child's academic life? _____

6. How have these symptoms impacted your child's social life? _____

7. How do these symptoms impact your child emotionally?_____

8. Has he/she ever had any of the following? If so, please circle and indicate child's age when occurred.

frequent nightmares; age _____
sleep walking; age _____
thumb sucking; age _____
stuttering; age _____

nail biting; age _____
excessive fear; age _____
bed wetting; age _____
soiling; age _____
difficulty with language/speech; age _____
difficulty with hearing; age _____
difficulty with vision; age _____
trouble with police; age _____
trouble with authorities; age _____
temper problems; age _____
sexual activity; age _____
pregnancy (self or girlfriend); age _____
cigarette use; age _____
alcohol use; age _____
gambling; age _____
criminal acts/non-violent; age _____
criminal acts/violent; age _____
truancy from school; age _____
running away from home; age _____
gang membership or participation; age _____
involvement with weapons; age _____
suicide attempts; age _____
eating disorder; age _____
mood difficulties; age _____
mental illness; age _____
fire starting; age _____
treatment/mental health; age _____
treatment/substance abuse; age _____
hurt animals; age _____

9. Are you concerned for your child about any of the following? If so, please circle and explain.

depression
fears
paranoid or suspicious thoughts
seeing or hearing things
low self-esteem
nervousness
hurting self
anxiety
suicidal thoughts or attempts
panic attacks

sleep problems
guilt
fighting
mood swings
memory problems
irrational beliefs
appetite disturbances
frequent headaches
frequent stomach aches
frequent gastric upset
feeling helpless
feeling hopeless feeling
inadequate setting fires
hostile feelings or actions
hurting animals
strange, unexplained thoughts, sensations, or feelings
poor concentration

10. What does your child know about his/her disorder and the symptoms associated with it?

11. Does he/she believe that this is a problem? Please explain.

12. What treatment, if any, has your child received in the past for these conditions/symptoms? Please explain.

13. What does your child know about the reasons s/he is seeing me?_____

14. How does s/he feel about seeing me?_____

15. What do you hope your child will receive from treatment? _____

16. What does your child hope to receive?_____

Family Background Information

1. What is your child's ethnicity? _____

2. Do you, your child, or your family identify with a particular cultural or ethnic group? Please explain. _____

3. Has this played an important role in any current problems with your child? Please explain.

_____
_____
_____
_____
_____

4. Are any religious affiliations and spiritual beliefs important to your family and to your child? If so, please explain._____

_____
_____
_____
_____
_____

5. In what geographic area has your child been raised?_____

_____
_____
_____
_____
_____

6. With whom has your child lived for his/her childhood?

Name	Relationship	Sex & Current Age	Child's Age during Cohabitation	Education & Job	Special Needs (if any)	Quality of Relationship with Client

Name	Relationship	Sex & Current Age	Child's Age during Cohabitation	Education & Job	Special Needs (if any)	Quality of Relationship with Client

Does the child have any biological parents, step-parents, siblings, half-siblings, or step-siblings not listed above? If so, please provide information:

Name	Relationship	Sex & Current Age	Education & Job	Where Does S/he Live?	Quality of Relationship with Client

Any additional information: _____

_____

_____

_____

3. Is your child adopted? Yes No

4. If so, what does he/she know about his/her adoption and birth parents? _____

_____

_____

_____

_____

_____

5. Who disciplines your child? For what type of behavior? How is your child disciplined?

6. Please describe any significant family history (include marriages, separations, substance/physical abuse, violence, death, disruptions, suicide/homicide).

7. What losses and/or deaths has your child experienced? How has she been affected by these?

8. Please describe the child's home environment, including relationships between family members.

9. Please describe the quality of the child's relationship with extended family (e.g., grandparents, aunts/uncles, cousins, etc.)

10. Is your family experiencing any particular stressors at the moment? Please explain._____

11. What social supports does your family have?_____

12. Is there a family history of health or mental health conditions relevant to the reasons your child is seeing me? If so, please describe._____

13. Has your child experienced any traumas during his/her life? If so, please describe._____

Physical Developmental History

1. Pregnancy and birth information (length of pregnancy, birth length and weight, complications, etc.) _____

2. Did the child meet the major physical milestones early, on time, or late? Explain._____

3. Has the child received immunizations typical for a child of his/her age? Yes No

Please explain any special circumstances related to immunizations._____

4. Has the child had any major illnesses? If so, please explain type, age of onset, and current status. _____

5. Does that child have any allergies? If so, please explain type, age of onset, etc._____

6. Is the child currently taking any medications? Please list.

Medication, Including Dosage	Prescribing Doctor	Condition Being Treated	Start Date of Meds	Side Effects?

7. Has the child previously been on other medications for a recurrent condition? Please explain. _____

8. Has he/she ever had any kind of head injury? If so, when and how? _____

9. Has he/she ever lost consciousness as the result of an injury? If so, when and how? _____

10. Have any of the child's physical illnesses or injuries affected him/her socially or emotionally? If so, how?_____

11. Is he/she sexually active? Yes No Unsure

Please explain any related circumstances._____

12. Has your child ever been abused? If so, please explain.

13. Please describe your child's diet (sensitivities, preferences, etc.)

14. Please describe the amount and type of physical activity that your child gets.

Academic History

1. Did your child meet all cognitive developmental tasks early, on time, or late? (E.g., talking, writing, counting, etc.)

2. Please describe your child's intellectual strengths/weaknesses.

3. Please describe your child's academic/intellectual development._____

4. Has he/she had any learning difficulties? If so, please explain. _____

5. Please describe the academic environments your child has been in, beginning with preschools.

Child's Age At Time	School/ Homeschool/Preschool	Reason for Change of School	Anything Noteworthy About This School (Esp. Positive or Negative Experiences)

Emotional and Social History

1. What activities is your child engaged in during leisure time?_____

2. Are you satisfied with your child's use of leisure (non-school) time? Please explain. _____

3. Please describe your child's relationships with peers._____

4. Who is your child closest to? Who does s/he consider her "best friends"?_____

5. Does he/she watch TV or play videos? If so, how many hours per day are spent at this activity? What types of shows and video games does s/heprefer?_____

6. Is the child's "screen time" monitored? If so, how?_____

7. Is there anything else you would like to tell me in order to help me understand your child and his/her situation? Please use this page (and the reverse) to provide any additional information. Additionally, if you have any evaluations, report/progress cards, etc. about your child that you think would help me understand him/her, please provide a copy of those.

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ADULT PSYCHOSOCIAL HISTORY FORM

Identifying Information

Client Name: _____

Date of Birth: _____

Circle One: Male Female Other (please specify):_____

Name of Person Completing This Form and Relationship to Client:_____
_____
_____

It is very important to your success that your therapist understands as much about you as possible. Please answer the questions as honestly as you can, and feel free to explain or add any other information. If a question does not apply to you or your situation or if you do not feel comfortable answering it here, please write N/A. This information, like all other information you provide, is confidential.

Presenting Problems

1. Have you been diagnosed with any mental health disorders (e.g., ADHD, generalized anxiety disorder, etc.)? If so, when, by whom and using which tests? (If you are providing copies of a test, reference that here.) _____
_____
_____
_____
_____
_____

2. What *symptoms* (e.g., poor organization, excessive worries, fidgetiness, etc.) have led you to seek therapy/coaching at this time? _____

3. For how long have you observed symptoms of these conditions? _____

4. How do these symptoms impacted your home life? _____

5. How have these symptoms impacted your work or academic life? _____

6. How have these symptoms impacted your social life? _____

7. How do these symptoms impact you emotionally? _____

8. Have you ever had any of the following? If so, please circle and indicate your age when occurred.

frequent nightmares; age_____
sleep walking; age _____
thumb sucking; age _____
stuttering; age _____
nail biting; age _____
excessive fear; age _____

bed wetting; age _____
soiling; age _____
difficulty with language/speech; age _____
difficulty with hearing; age _____
difficulty with vision; age _____
trouble with police; age _____
trouble with authorities; age _____
temper problems; age _____
sexual activity; age _____
pregnancy (self or girlfriend); age _____
cigarette use; age _____
alcohol use; age _____
gambling; age _____
criminal acts/non-violent; age _____
criminal acts/violent; age _____
truancy from school; age _____
running away from home; age _____
gang membership or participation; age _____
involvement with weapons; age _____
suicide attempts; age _____
eating disorder; age _____
mood difficulties; age _____
mental illness; age _____
fire starting; age _____
treatment/mental health; age _____
treatment/substance abuse; age _____
hurt animals; age _____

9. Are you concerned about any of the following? If so, please circle and explain.

depression
fears
paranoid or suspicious thoughts
seeing or hearing things
low self-esteem
nervousness
hurting self
anxiety
suicidal thoughts or attempts
panic attacks
sleep problems
guilt
fighting
mood swings
memory problems
irrational beliefs
appetite disturbances

frequent headaches
frequent stomach aches
frequent gastric upset
feeling helpless
feeling helpless
feeling inadequate
setting fires
hostile feelings or actions
hurting animals
strange, unexplained thoughts, sensations, or feelings
poor concentration

10. Do you believe that any of the above are problematic? this is a problem? Please explain.

11. What do you know about your disorder(s) and the symptoms associated with it? What other questions do you have about it?

12. What treatment, if any, have you received in the past for these conditions/symptoms? Were any of these particularly successful or not successful? Please explain.

13. How do you feel about seeing me?

11. What do you hope to receive from treatment? _____

12. Are there others in your life who are encouraging you to seek treatment? If so, what do they hope you will accomplish during therapy? _____

Family Background Information

1. What is your ethnicity? _____

2. Do you, now or ever, identify with a particular cultural or ethnic group? Please explain.

3. Has this played an important role in any current problems? Please explain.

4. Are any religious affiliations and spiritual beliefs important to you, now or ever? If so, please explain._____

5. In what geographic area were you raised and have you lived?_____

6. With whom have you lived throughout your life

Name	Relationship	Sex & Current Age	Age during Cohabitation	Education & Job	Special Needs (if any)	Quality of Relationship with You

Do you have any biological parents, step-parents, siblings, half-siblings, or step-siblings not listed above? If so, please provide information:

Name	Relationship	Sex & Current Age	Education & Job	Where Does S/he Live?	Quality of Relationship with You

Any additional information: _____

_____

_____

_____

_____

_____

7. Were you adopted? Yes No

8. If so, what do you know about your adoption and birth parents? _____

9. Please describe any significant family history (include marriages, separations, substance/physical abuse, violence, death, disruptions, suicide/homicide). _____

10. What losses and/or deaths have you experienced? How have you been affected by these?

11. Please describe your home environment, including relationships between family members._____

12. Please describe the quality of your relationship with extended family (e.g., grandparents, aunts/uncles, cousins, etc.)_____

13. Are you (or anyone close to you) experiencing any particular stressors at the moment?

Please explain._____

_____

_____

_____

_____

_____

14. What social supports do you have?_____

_____

_____

_____

_____

_____

15. Is there a family history of health or mental health conditions relevant to the reasons you are seeing me? If so, please describe._____

_____

_____

_____

_____

_____

16. Have you experienced any traumas during your life? If so, please describe._____

_____

_____

_____

_____

_____

Physical Developmental History

1. Pregnancy and birth information (length of pregnancy, birth length and weight, complications, etc.) _____

2. Did you meet the major physical milestones early, on time, or late? Explain._____

_____

_____

3. Have you received immunizations typical for a person of your age? Yes No

Please explain any special circumstances related to immunizations._____

4. Have you had any major illnesses? If so, please explain type, age of onset, and current status. _____

5. Do you have any allergies? If so, please explain type, age of onset, etc._____

6. Are you currently taking any medications (including supplements). Please list.

Medication, Including Dosage	Prescribing Doctor	Condition Being Treated	Start Date of Meds	Side Effects?

7. Have you previously been on other medications for a recurrent condition? Please explain.

8. Have you ever had any kind of head injury? If so, when and how? _____

9. Have you ever lost consciousness as the result of an injury? If so, when and how? _____

10. Have any of your physical illnesses or injuries affected you socially or emotionally? If so, how?_____

11. Are you sexually active? Yes No

Please explain any related circumstances that may be related to the issues for which you are seeking treatment.

12. Have you ever been abused or victimized? If so, please explain._____

13. Please describe your diet (sensitivities, preferences, etc.)_____

14. Please describe the amount and type of physical activity that you get.

15. Please describe your sleep cycle.

Academic/Work History

1. Did you meet all cognitive developmental tasks early, on time, or late? (E.g., talking, writing, counting, etc.)

2. Please describe your intellectual strengths/weaknesses.

3. Please describe your academic/intellectual development.

4. Do you have any learning difficulties? If so, please explain.

5. Please describe the academic environments you have been in.

Age At Time	School/ Homeschool/Preschool	Reason for Change of School	Anything Noteworthy About This School (Esp. Positive or Negative Experiences)

6. What is your occupation?_____

7. Have you had other occupations in the past?_____

8. Do you have a history of occupational stresses? Please describe.

9. Do you have educational or occupational dreams or goals? Please describe.

Emotional and Social History

1. What activities do you engage in for fun, both now and previously in your life?

2. Are you satisfied with your use of leisure (non-school) time? Please explain.

3. Please describe your relationships with friends and colleagues, both now and in the past.

4. Who are you closest to? Who do you consider your "best friends"?

_____

_____

5. Do watch TV or play videos? If so, how many hours per day are spent on these activities? What types of shows and video games do you prefer?_____

_____

_____

_____

_____

_____

6. Is there anything else you would like to tell me in order to help us understand you better. Please use this page to provide any additional information.