Behavior Therapy Associates

Larissa Maley, Ph.D. – Licensed Clinical Psychologist
9426 Indian School Road NE, Suite #1
Albuquerque, NM 87112
505-345-6100

General Information:

Today's Date	
Service Requested (circle one):	Individual Family Couples
Referred by:	
Preferred start date of treatment:	
Primary reason(s) for seeking treatment:	

Client Information:

Street Address:	
City / State / Zip:	
Preferred phone #:	
Age	
If under 18, guardian's name and contact#:	
Who lives in your home:	
Gender (circle one):	Female Male Transgender
Occupation:	
Highest grade/degree completed:	
Relationship status:	Partnered Single Separated/Widowed
If in a relationship, partners name:	
Partners age & occupation:	
Children:	Yes No
Children's ages and living situation	

Insurance Information:

Primary Insurance Company:	
Copay:	
Insured's Name:	
Policy ID:	
Group #:	

Secondary Insurance Company:	
Copay:	
Insured's Name:	
Policy ID:	
Group #:	

Emergency Contact Information:

Name and Relationship:	
Phone #:	

Medical and Psychiatric History:

Current mental health treatment:	Yes No
If yes, type, name and contact#:	
Current mental health diagnosis (if known):	
Past mental health treatment:	Yes No
If yes, type and length in treatment:	
Past mental health diagnoses (list):	
Have you ever been hospitalized for a mental health issue?	Yes No
If yes, when and for how long?	
Have you ever attempted suicide?	Yes No
Have you engaged in self-harm (cutting, burning)?	Yes No
Current medical issues / problems:	
Past medical issues / problems / hospitalizations:	
Medications and doses currently taking (list):	
Primary care physician name and contact#:	

Substance use and history:

Do you drink alcohol?	Yes No
If yes, how often and how much do you typically drink?	
Do you use tobacco products?	Yes No
If yes, how often and how much do you typically use?	
Do you use other drugs?	Yes No

If yes, what kind, how often and how much do you typically use?	
Have you ever had a problem with substances or been in treatment for substance use issues?	Yes No
If yes, when and for what?	
Have you experienced any of the following as a child or adult?	
Sexual abuse:	Yes No
Physical abuse:	Yes No
Emotional abuse / Neglect:	Yes No
Victim of a crime:	Yes No
Serious natural disaster or accident:	Yes No
Describe any past or future legal issues:	
Describe any problems you have with finances, work or school:	
Describe your hobbies, interests and activities:	
How would you rate your current support system?	Excellent Good Fair Poor
How would you rate your current level of stressors?	Mild Moderate Extreme

OUTPATIENT PSYCHOTHERAPY CONTRACT AND INFORMED CONSENT

Larissa Maley, Ph.D.

This document contains important information about my professional services and business policies. Please read it carefully and ask me any questions that arise. Your signature indicates that you understand and accept the terms of treatment.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the particular problems being treated and the theoretical approach practiced by the providing psychologist. It is therefore important that you take care in selecting a therapist that fits your style and treatment goals. Our first few sessions will involve an evaluation of your current problems, concerns, and needs. By the end of the evaluation period, I will offer you my clinical impressions and a recommended approach to treatment. During this time, it is important that we both consider whether I am the best person to provide the services you need to meet your specific treatment goals. If indicated, a referral to a more appropriate therapist will be provided (e.g., your presenting problem is outside the scope of my clinical expertise). As therapy involves a commitment of time, energy, and money, it is important that you feel comfortable working with me. The goals of therapy are arrived at by mutual collaboration between us. The goals we establish will be reviewed during the course of our work in order to assess and/or modify the focus of therapy according to your needs. If any questions or concerns about our work together arise at any point during treatment, please bring them to my attention.

PROFESSIONAL FEE INFORMATION

SESSION FEES: The standard fee at Behavior Therapy Associates, LLC for an initial diagnostic interview is $225.00 with insurance. The standard fee for ongoing psychological services or assessment with insurance is $200.00 for a 55-60-minute session. New Mexico Gross Receipts tax is included in these rates.

INSURANCE: Dr. Maley is accepting only self-pay clients at this time but is in the process of applying to insurance panels for Presbyterian, New Mexico Health Connections, BCBS, Medicare and Tricare. Until that time, you will be responsible for paying the “SELF-PAY” fees described below at the time of service.

SELF-PAY: The fee for an initial evaluation with Dr. Maley is $200 and the fee for ongoing sessions is $155.

PAYMENT: Payment is due at the time services are rendered. Accepted methods of payment are cash, check, or credit card. Checks should be made payable to Larissa A. Maley, PhD. If you pay by check and the bank refuses it, a charge of $25.00 will be assessed in addition to the original amount of the check. If your account has not been paid

for more than 90 days and terms of payment have not been arranged with me, your account may be sent to a Collection Agency and its cost added to the amount you owe.

MISSED SESSIONS: If you must cancel an appointment, please provide at least 24 hour notice – by Friday if you have a Monday appointment. The fee for a missed session that is not canceled with 24 hour notice is $75.

INFORMED CONSENT

I have chosen to receive psychological services from Larissa A. Maley, Ph.D., a provider at Behavior Therapy Associates. My choice has been voluntary, and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychological treatment is a cooperative effort between me and my therapist, I will work with my therapist to the best of my ability to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed that is upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that the ability of my therapist to provide useful feedback and guidance to me is dependent upon the accuracy of the information I provide about myself.

My rights include:

- The right to be informed of the steps and activities involved in receiving services
- The right to confidentiality under federal and state laws relating to the receipt of services
- The right to humane care and protection from harm, abuse, or neglect
- The right to make an informed decision whether to accept or refuse treatment
- The right to contact and consult with counsel at my expense
- The right to select practitioners of my choice at my expense

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self and/or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that my therapist may contact me to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

I understand that my therapist will be required to provide basic clinical information, including diagnoses, to my insurance company in order to receive payment for services, and that my therapist has no control over how my insurance company handles my private information and that my therapist cannot be held liable for the actions of the insurance company.

If you have questions about fees, payment plans, insurance, or other financial concerns, please discuss these with me.

Please be sure, as well, to read the **Notice of Privacy Practices** available in the waiting area.

Your signature below verifies that you have read, understand, and agree with the information provided in the section titled "**OUTPATIENT PSYCHOTHERAPY CONTRACT AND INFORMED CONSENT".**

This also verifies that you have read and understand the Notice of Privacy Practices and have been offered a copy for your records. Your signature also authorizes the release of any medical or other information necessary to process this claim with your insurance company.

Signature of patient:_____Date:_____

Print patient name: _____Date: _____

If client is under the age of 15, parental consent for treatment is required.

Signature of parent or legal guardian:_____Date:_____

Print name of parent or legal guardian: _____Date: _____