BILL MALONEY, LCSW

2401 Pennsylvania Ave. Suite 103-A Wilmington, DE 19806
Phone:(302) 656-8511 Fax:(302) 656-8512 e-mail: Bill@Maloney.com

Thank you for calling for an appointment. I am sending you this letter to confirm your appointment and to introduce you to the procedures of this office.

Your appointment is on

____at ______________________________.

Those expected to be present at this appointment are:

____

I ask that we agree between us that appointments, once made, not be changed by either of us unless absolutely necessary. Sessions are expected to take priority over other activities for all those scheduled to attend, and should be rescheduled only for serious illness or emergencies which make attendance impossible. I reserve the right to charge for appointments changed with less than 24 hours notice, the amount charged not to exceed the normal fee for the session. Most insurance companies will not pay for any part of a missed session, so the fee will be entirely the responsibility of the party missing the session.

My usual fee is $125 per session. Sessions normally last about 45 minutes but can be shorter or longer depending on circumstances. Fees are paid at the beginning or end of the session with cash or check; credit or debit, not accepted. If paying by check please have your check made out before the start of the session. Other financial arrangements including insurance coverage can be made. Please inform me of your specific type of medical insurance so, if necessary, we can get pre-authorization for our sessions.

I am generally in the office Monday thru Thursday. There are variations in this depending on circumstances. I will return messages as quickly as possible. I discourage use of the telephone for treatment issues, but will make every effort to be available to you for genuine emergencies. I will also make an effort to schedule an extra session between regular appointments should the need arise. If you are calling outside of my usual office hours, you may call my home at (610) 869-0482. I usually carry a cell phone with voice mail. The number and instructions are on my answering machine. I will always have a number for a covering therapist on my answering machine if I am out of town. Please remember to speak slowly and clearly when leaving a message on the answering machine. If I pull my messages from a remote location, I need to be able to understand your name and number to return the call. **Speak clearly and slowly into the phone and always leave your number when calling me.**

Other **emergency back-ups** include:
Mobile Crisis Unit (302) 577-2484
Contact (302) 761-9100
911

Regarding **confidentiality**: when clients are referred to me by EAPS, Managed Care, or consulting psychiatrists, physicians, psychologists, school personnel, lawyers or clergy, I request that you sign a "Release of Information" form so I may contact the referral source in order to discuss matters pertinent to the referral.

The only time I may break confidentiality is when your life or another's life is in danger or when a child may be or is being physically or sexually abused.

Directions:
2401 Pennsylvania Ave is in the Devon. It is the 14 story yellow brick building that is less than a mile north of downtown Wilmington on Pennsylvania Ave. (Route 52). I-95 exit is Delaware Ave. going north (away from the city). Coming from Route 141 take Route 52-South past Tower Hill school. There is parking all around the building and on the street as well. The entrance is in the center of the building on either the front or back. A doorman will let you in for nighttime appointments. Rest rooms are on the hallway. I’m the last office on the left before you reach Rockford Perk café.

I have read, understand and agree to the above material.

____
(Signature)

____
(date)

INTAKE INFORMATION

NAME ____ DATE of BIRTH__________________

ADDRESS_____________________________________ CITY_________________________________

STATE / ZIP_________________________________ SOCIAL SECURITY #______________________

HOME PHONE_____________________________ OTHER PHONE #'s_____________________________

CELL PHONE______________________________ EMAIL ADDRESS ______________________________

HIGHEST LEVEL OF EDUCATION ACHIEVED ____________ OCCUPATION__________________________

WORK PHONE____________________ EMPLOYER___________________ HOW LONG?____________

ADDRESS____

RELATIONSHIP HISTORY *NAMES OF SIGNIFICANT OTHERS* *DATES TOGETHER*

CURRENT____ __________________

PAST ____ __________________

____ __________________

____ __________________

NAME SPOUSE / PARTNER ______________________________________DOB____________________

OCCUPATION ____BUSINESS PHONE_____________

EMPLOYER _____________________________ HOW LONG _____________

HIGHEST EDUCATION LEVEL ACHIEVED _____________________________

OTHERS LIVING IN YOUR HOME:__________________________________ ________ _____ _____

NAME *DOB* *AGE* *SEX*

____ ________ _____ _____

____ ________ _____ _____

____ ________ _____ _____

____ ________ _____ _____

NAME OF MEDICAL INSURANCE ____

GROUP # _____________________________SUBSCRIBER # _________________________________

REFERRED BY: _________________________ FAMILY PHYSICIAN _____________________________

MEDICATIONS I TAKE: ____

I have read and understand the procedures of this office. I authorize Bill Maloney to release information to my insurance carrier regarding treatment and billing. Insurance carriers may pay Bill Maloney directly for services rendered.

____ __________________

SIGNED *DATE*

BILL MALONEY, LCSW

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A Federal law, the Health Information Portability and Accountability Act of 1996, known as *HIPAA*, requires that I inform you about how this office may use personal health information that is gathered in order to provide services to you. I am providing you with this Notice of Privacy Practices (NPP). The NPP describes how I may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This NPP also describes your rights regarding health information this office maintains about you and a brief description of how you may exercise these rights. Bill Maloney, LCSW requests that you sign an acknowledgement that you have received a copy for your own record.

PLEASE REVIEW CAREFULLY…

NOTICE OF PRIVACY PRACTICES

I am required by applicable Federal and State law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your Protected Health Information (PHI). I must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about my privacy practices, or for additional copies of this Notice, please refer to Sections II F and II G of this Notice. This Notice is effective on April 14, 2003.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. **Permissible Uses and Disclosures Requiring Your Written Authorization:**
To ensure the maximum protection of a client's PHI, I will require written authorization to use and disclose any PHI for certain purposes as described below:

1.**Treatment, Payment, and Other Healthcare Operations (TPO):** To use or disclose PHI in order to provide treatment to clients; so that services are appropriately billed to, and payment is collected from, health plans; and in connection with health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

2. **Training and Publicity:** A specific consent form will be used for use in videotaping and audiotaping, if applicable. Consent for special events and activities that will be publicized by various news media, if applicable, will require use of a special publicity consent form.

3. **Psychotherapy Notes:** Notes recorded by your clinician documenting the contents of your counseling session are called "Psychotherapy Notes." These will be used only by your clinician and will not otherwise be used or disclosed (including TPO) without your written authorization. As required by HIPAA standards, psychotherapy notes will be kept separate from the rest of your case record.

4. **Marketing Communications:** I will not use your health information for any marketing communications without your written authorization.

5. **Other Uses and Disclosures:** Other uses and disclosures will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your insurance company, school, or attorney. You may revoke any such authorization at any time.

B. **Uses and Disclosures that will not require your written authorization include:**
I may use or disclose PHI when required or permitted to do so by law. For example, (1) To appropriate authorities if I reasonably believe that a client is a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes (2) To avert a serious threat to the health or safety of a client or the health or safety of others (3) For public health activities (4) For health oversight activities including disclosures to state or federal agencies authorized to access PHI (5) To judicial and law enforcement officials in response to a court order or other lawful process

(6) For research when approved by an institutional review board and (7) To military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

Records of Disclosure: **All records of disclosure of PHI (with and without client authorization) will be maintained in the case record as required by HIPAA standards. Records of Disclosure will be maintained for at least six (6) years from April 14, 2003. This record will contain (1) Date of the Disclosure (2) Name, and address if known, of the entity or person who received the PHI (3) Brief description of the PHI disclosed and (4) Brief statement of the purpose of the Disclosure.**

II. YOUR INDIVIDUAL RIGHTS

A. **Right to Inspect and Copy:** You may have reasonable access to your records. Access will be granted within a reasonable time frame and no later than 30 days. All requests for access must be made in writing. I may charge a fee for the costs of copying and sending any records requested. Any requests you make to access case records will be noted in your file. In circumstances when there is compelling evidence that access would cause harm to the client, I may restrict the client's access to the record. In these cases, I must document the rationale for withholding some or all of the record. A parent or legal guardian of a minor will not have access to certain portions of the minor's medical record as consistent with State law (i.e., pregnancy, sexually transmitted diseases).

B. **Right to Request Amendment:** You may request that I amend your health information. This request must be in writing, and must explain why the information should be amended. I may deny your request under certain circumstances. However, your request will be included in your case record.

C. **Right to Request Restrictions:** You have the right to request in written form a restriction on portions of your overall PHI.

D. **Right to Alternative Communications:** I will accommodate any reasonable written request that you make to receive PHI by alternative means of communication or to be sent to alternative locations.

E. **Right to Accounting of Disclosures:** Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003.

F. **Questions and Complaints:** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact the Privacy Officer – Bill Maloney, LCSW of this office at (302) 656-8511. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with this agency or the Director.

G. **Right to Obtain Notice:** You have the right to obtain an additional paper copy of this Notice of Privacy Practices by submitting a request to the Privacy Officer at any time.

H. **Changes to this Notice.** I may change the terms of this Notice at any time. At such time, I will make these changes effective for all PHI that it maintains, including any information created or received prior to issuing the new notice. I will also post the revised Notice in my waiting area. You may also obtain a copy of any Notice revisions by contacting the Privacy Officer.

Acknowledgement of Receipt of

Notice of Privacy Practices

By my signature below I, ____, acknowledge that I have received a copy of the Notice of Privacy Practices for Bill Maloney, LCSW.

____ ____________________

Signature of client (or personal representative) **Date**

If this acknowledgment is signed by a personal representative on behalf of the client,

Please complete the following:

Personal Representative's Name:

Relationship to Client:

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other** ***(Please specify)***

____

____

This form will be retained in your client record.

INFORMED CONSENT FOR TREATMENT CONTRACT

I, ____

(first) *(middle)* *(last)*

of ____

(street address) *(city)* *(state)* *(zip code)*

consent to receive services offered by Bill Maloney, LCSW and that my participation will be required.
I understand that Bill Maloney will abide by all tenets of confidentiality and will release/obtain information only with my permission—except in the following situations:

- With my written consent
- If required by the mandatory reporting law for suspected child abuse or neglect.
- In the event I present a danger to myself or someone else.
- In the event the therapist and/or case records are subpoenaed.
- If my insurance company/EAP requires that my primary care physician be informed of my diagnosis and treatment plan.
- When insurance or managed care companies require an audit, pre-authorization for services, diagnosis, presenting problem and/or treatment plan.
- When the therapist is consulting with another professional, making every effort to avoid revealing my identity, and with the understanding that the consultant will uphold confidentiality.
- For the purpose of reminding me of my appointments.
- To inform me about treatment alternatives or other health-related services.
- For Healthcare Operations such as quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

I have read this form, had it explained to me, and had the opportunity to ask questions. I understand its contents. By signing this document I agree to all of the above conditions:

______________________________ ____________ ______________________________ ____________

Client Signature *Date* *Youth Signature (optional)* *Date*

(Parent/Guardian if client is minor child under 18)

______________________________ ____________

Signature of Witness *Date*