Mary Myers, Ph.D.
Licensed Clinical Psychologist

1188 Bishop Street, Suite 3512
Honolulu, Hawaii 96813
Phone (808) 550-0991
FAX (808) 550-0992

INTAKE INFORMATION – ADULT

Patient Name: _____ Date of Birth: ____/____/____
Address: _____
Telephone: _____ SSN: _____ Email: _____
Marital Status: (please circle) Single Married Widowed Divorced Separated

Would you like a text message reminder for future appointments? YES / NO

EMPLOYMENT INFORMATION

Have you served in the military? YES / NO If "YES", what branch? _____ Discharge states: _____
Employer: _____ Occupation/Profession: _____ Years at this job: _____

ACADEMIC INFORMATION

Highest Level of Education Completed: _____ Degree Obtained: _____
College/University (if applicable): _____

INSURANCE

Primary Insurance Company: _____ Subscriber/Member ID: _____
Secondary Insurance Company: _____ Subscriber/Member ID: _____

IN CASE OF EMERGENCY

1) Emergency Contact Name: _____ Phone: _____
Referred by: _____
Have you been in therapy before? YES / NO If "YES", indicate when and for what:

_____

Briefly explain what problems you are currently experiencing.

_____

Have you been or are you currently involved in any other therapeutic groups or support groups such as AA/NA, Anger Management, and Parenting Classes? YES / NO
If "YES", indicate which group: _____
Have you ever been admitted to a psychiatric hospital? YES / NO If "YES", indicate reason & date(s) of hospitalizations: _____
Have you had any previous Suicidal Attempts: YES / NO If "YES", indicate reason & approximate date(s):

_____

_____

Are you currently taking any medications? YES / NO If "YES", indicate name of medication, dosage, how often the medication is prescribed, and the name of the prescribing physician:

Medication _____ Dosage _____ How often _____ Physician _____

Medication _____ Dosage _____ How often _____ Physician _____

Medication _____ Dosage _____ How often _____ Physician _____

Please circle any of the following problems/issues you are currently experiencing:

1. Nervousness
2. Depression
3. Grief/Loss/Death
4. Unhappiness/Sadness
5. Self-Control
6. Work Problems
7. Suicidal Thoughts
8. Concentration
9. Health Issues
10. Stomach Trouble
11. Confidence
12. No Direction
13. Finances
14. Headaches
15. Insomnia
16. Sexual Issues
17. Drug Use/Abuse
18. Hearing Voices
19. Friends
20. Relationship
21. Separation
22. Divorce
23. Relaxation
24. Legal Matters
25. Making Decisions
26. Marriage
27. Children
28. Being a Parent
29. Trust Issues
30. Career Choices
31. Memory
32. Tiredness
33. Anger/Temper
34. Alcohol Use
35. Anxiety/Fears
36. Confusion
37. Stress
38. Shyness
39. Sleep
40. Self-Esteem
41. Inferiority
42. Loneliness
43. Education
44. Nightmares
45. My Thoughts
46. Appetite
47. Overeating
48. Energy
49. Ambition
50. Paranoia
51. Smoking
52. Other (Specify below)

Your primary care physician or other medical doctor you are seeing:
Name: _____ Phone: _____ Date of last medical exam: _____

Place a ✓ if you have (or have you ever had) any of the following medical problems:

__ Diabetes
__ Cirrhosis
__ Hepatitis
__ Anemia
__ Gout
__ High Blood Pressure
__ Gastritis
__ Pancreatitis
__ Thyroid Problems
__ Allergies/Asthma
__ Head Injury
__ Heart Condition
__ Skin Rash
__ Liver Problems
__ Kidney Disease
__ Stroke
__ Arthritis
__ Chest Pain
__ Hernia
__ Sinus Problems
__ Traumatic Brain Injury
__ Headaches
__ Colitis
__ Bronchitis
__ Gallbladder Problems
__ Venereal Disease
__ Convulsions/Seizures
__ Cancer or Tumors
__ Deafness or Decrease hearing
__ Weight Problems
__ Chronic Pain
__ Covid-19

__ Other (Specify below):

Use of alcohol/drugs (please complete this section ONLY if applicable)

Type	**How Used**	**Age Started**	**Amount**	**Frequency**	**Last used**

Previous Alcohol/Drug Treatment

Dates of Treatment	**Type of Treatment**	**Name of Treatment Facility**

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POLICIES AND PROCEDURES

Welcome! This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them during our meeting. When you sign this document, it will represent an agreement between us.

WHAT TO EXPECT

The purpose of the first "intake" session is to evaluate your needs through an interview process. During this session, I will ask you questions about issues you're currently experiencing, your background, and your goals for therapy. By the end of the session, I will be able to offer you some first impressions about the recommended course of therapy or other resources that may be helpful. On some occasions, I may recommend a different type of service or specialty provider, for which you will be given referrals and assisted with next steps. Therapy begins if we mutually decide to continue after the initial evaluation session. The duration and frequency of follow-up sessions can vary depending on your needs. However, in the outpatient office setting, the frequency of therapy sessions is typically weekly or twice a month, with sessions lasting approximately 45 minutes.

24-HOUR CANCELLATION POLICY

If you are prevented from attending your scheduled session and do not cancel your appointment at least 24 *business hours* in advance, you understand that you will be charged for no-shows or late cancellations. Keep in mind that frequent cancellations will put you at a low priority if/when scheduling future appointments. This is standard practice in the field and takes into account that you are not just paying for services rendered but reserving a time slot that I will not be able to offer to someone else on short notice.

An unavoidable emergency would be exempt from the policies above. An emergency would be a life/death situation that is beyond your control. After the emergency, please bring the documentation, or at least let us know the situation for a consideration.

INSURANCE REIMBURSEMENT & CO-PAYMENTS

If you have health insurance, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, I am willing to call the insurance company on your behalf to obtain clarification.

If any changes occur to your insurance policy and carrier, please inform the office manager as soon as possible. Failure to report changes may result in patient responsibility for uncovered changes.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company I will try to keep that information limited to the minimum necessary.***

Please make your co-payment at the time of your office visit unless you have made other arrangements. If you have made arrangements for a bill to be sent to you, please remit your co-payment within 30 days. A late charge of a 1.5% will be applied to payments if it is not received within 30 days to cover the additional costs. Whenever account goes over the 90 days or $200, it may be referred to a collection agency which will incur additional fees.

FEES
Intake session 45-50 minutes $250
Psychotherapy session 45 minutes $235
Psychotherapy session 60 minutes $295
Services such as writing letters, sending medical records (attorneys), attendance at meetings with other professionals that you have requested are generally not covered by insurance and you will be responsible for payment of such services $295/hour.

CONTACTING ME BETWEEN SESSIONS
I am often not immediately available by telephone. I am usually in my office Monday thru Thursday from 11am until 7 pm. I do not answer the phone when I am with a patient. If you leave a voicemail message, I will make every effort to return your call within 24 hours, **with the exception of weekends and holidays**. If you do not leave a message, I do not return calls. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist or psychiatric nurse on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague who will provide emergency coverage while I'm away.

CONFIDENTIALITY [for adult patients]
In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.
In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child or an elderly person or disabled person is being abused or has been abused, I may be required to make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I may be required by law to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice that I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney. Upon request, I will provide you with relevant portions or summaries of the state laws regarding these issues.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

PATIENT SIGNATURE _____ **DATE** _____
(Parent/Guardian if patient is a minor)

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INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

BENEFITS AND RISKS OF TELEPSYCHOLOGY

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

ELECTRONIC COMMUNICATIONS through the Telepsychology App, *Doxy.me*
I conduct telepsychology through Doxy.me, a free, fully encrypted video therapy application. It works similarly to Zoom or Facetime. However, full-encryption means that your privacy is preserved and therapy sessions remain absolutely confidential.

CONFIDENTIALITY
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Policies And Procedures Form still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

APPROPRIATENESS OF TELEPSYCHOLOGY
From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

EMERGENCIES AND TECHNOLOGY
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. By signing this consent form, you authorize me to contact your emergency contact person as needed during such a crisis or emergency.

Your emergency contact person is:

Name:_____ **Phone:** _____

If the session is interrupted for any reason, such as technological connection fails, and you are having an emergency, do not call me back; instead, call 911 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

INTERRUPTIONS DUE TO TECHNOLOGICAL ISSUES
If the session is interrupted and you are not having an emergency, disconnect from the session ad I will wait two (2) minutes and re-contact you via the telepsychology platform on which we

agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you. If you do not have my phone number, you may dial the office. The office number is (808)-550-0991.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

FEE
The same fee rates will apply for telepsychology as apply for in-person psychotherapy. (See Policies and Procedures Form)

RECORDS
The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

INFORMED CONSENT
This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend of any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

Patient/Client First Name	**Patient/Client Last Name**
Patient/Client Signature	**Date**
Parent/Client Signature (If client is a minor)	**Date**

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MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will you ask you to provide me with a copy of most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communication with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members during your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality **cannot be maintained** when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe that they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and try to prevent the occurrence of such harm.

- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgement to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that it appears that a child is being neglected or abused – physically, sexually or emotionally – or that it appears that they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of – or might be upset by – but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgement to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example:*** If your child tells me that he/she has tried alcohol at a few parties, I will keep this information confidential. If your child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I will not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I will not keep that information confidential.
>
> ***Example:*** If your child tells me that he/she is having voluntary, protected sex with a peer, I will keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe conditions, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You could ask in the forms of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of Hawai`i may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge form requiring testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem,* or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform wok related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $ ____ per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature _____ Date _____

*For very young children, the child's signature is not necessary.

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

____ ____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/pr may be asked to participate in therapy sessions as needed.

____ ____ Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

____ ____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgement, unless otherwise noted above.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____