Kristen Maloney, LMFT

Instar Therapy

Counseling Policies

I am excited and honored to have the opportunity to work with you. This packet is meant to provide you with information that might be helpful in making informed decisions regarding these services. Please feel free to ask questions at any time.

Credentials: I am a Licensed Marriage and Family Therapist in Tennessee -**License #1267**. I hold a master's degree in Marriage and Family Therapy from Trevecca Nazarene University and a bachelor's degree in Child Development and Family Studies from Middle Tennessee State University.

I have completed an externship in Emotionally Focused Therapy (EFT) and am also certified in the Prepare/Enrich Relationship Assessment for premarital couples.

****Should you have questions about the counseling treatment provided, please feel free to address them with me in session.**

Appointments:

Counseling services are by appointment only, and sessions last 45-50 minutes. Because the appointment is reserved for you, I will require that cancellations/rescheduling of appointments occur at least 24 hours in advance of your scheduled appointment. The rate of the full session is charged for missed appointments or cancellations made with less than a 24-hour notice. You may cancel or reschedule your appointment via phone call, text or e-mail.

I have read and understand this policy (please initial) _____

Fees and Charges:

My standard fee for a counseling session is $85.00 per clinical hour (45-50 min). This fee also includes my time, on your behalf, outside of our session, including record keeping and preparation. I accept cash, check or Visa, MasterCard, American Express, and Discover credit cards. **Please note that a $2.00 service charge will be added to the fee if you choose to pay by credit card.** Please be sure that you have the necessary funds available when choosing your payment method, as any fees I may incur for returned checks when processing your payment will be billed back to you. **I require that a credit or debit card be kept on file in order to bill for any missed appointments.**

I have read and understand this policy (please initial) _____

Availability and Messages:
I do not accept phone calls or check e-mail while I am with clients or outside of my regular business hours. During those times you may leave me a voicemail. It is my policy to return calls, texts or e-

mails within 24 hours during the work week (Monday-Friday). In case of an emergency, please call the crisis hotline at 615-244-7444 or 911.

I have read and understand this policy (please initial) _____

Use of Email, Phone and Text Messaging:

I will only use electronic communication for scheduling or discussing appointments. As tone of voice, emotions and other important communication factors are sometimes assumed or misunderstood in electronic communication; I feel that it is important to restrict therapeutic work to our scheduled sessions. In the case that a client feels it necessary to send an update/information to me in between sessions, the following shall be adhered to:

1. The client will be billed for the time it takes to read, respond to, print and file all e-mail(s).

2. If, in the e-mail communication, the client indicates, either outright or by insinuation that they are planning on harming themselves or someone else, the legal mandate of confidentiality shall be applied. The client will be billed for the time it takes to assess the situation, contact the client, develop a safety plan and contact all appropriate emergency contacts, safety and medical personnel in order to ensure the client's safety.

I have read and understand this policy (please initial) _____

Counseling:

Counseling can be extremely beneficial; and at the same time, there are some risks. The risks may include the experience of intense and unwanted feelings such as (but not limited to): sadness, fear, anger, or guilt. It is important to remember that these feelings may be natural and normal, and are an important part of the counseling process.

Other risks of counseling may include, but are not limited to: recalling unpleasant life events, facing unpleasant thoughts and beliefs, increased awareness of feelings, values and experiences, alteration of an individual's thinking, and calling into question some or even many of your beliefs and values. As your counselor, I will be available to discuss any of your assumptions, problems, or the possible negative side effects of our working together. Periodically we will address your progress and re-evaluate treatment as needed. However, please feel free to address these or other issues with me at any time.

Although the occurrence is infrequent, there may be a time when a patient's distress remains or becomes so high that hospitalization or the use of medication must be considered. I am not a physician and do not prescribe medication; however, at times I may encourage you to consider seeking medical attention. In cases where hospitalization and/or medication may be required, this will be discussed in advance with you and, if necessary, with other responsible parties.

I have read and understand this policy (please initial) _____

Client Rights:

At any time you may question and/or refuse counseling or diagnostic procedures or ask questions about the process and course of the counseling. Clients are given the respect of the highest level of confidentiality. There are, however, important exceptions to confidentiality that are legally mandated. In general terms, these exceptions are:

1. If I judge that a client has any intention to harm either himself/herself or another individual. If this situation arises I must notify appropriate parties.

2. If I become aware of any incident of suspected child or elder abuse, neglect, or molestation. If this situation arises I must report it in order to protect the child/children or elder(s) involved.

3. In legal cases, my records may be subpoenaed by the court.

Confidentiality will be respected in all cases, except as noted above. In cases where, in my judgment, the maintenance of confidentiality is, in fact, destructive to you, I will inform you of my concern, and you will have the final decision as to whether or not I maintain confidentiality.

When needed, you will be asked to sign a "Consent for Release of Confidential Information" form which will allow me to discuss your evaluation and/or treatment with others (e.g. Physicians, previous counselors, etc.). If you wish, you may also limit the time of release by an expiration date, and/or limit what I have permission to discuss by writing these instructions on the release form.

I have read and understand this policy (please initial) _____

Dynamics in Couples Therapy

PURPOSE: To ensure that effective treatment occurs for all clients.

POLICY: if I identify dynamics of power and control as a part of pervasive relationship patterns, I will cease providing conjoint couples work and will (with few exceptions) refer the aggressor for specialized treatment outside of myself, until it is deemed appropriate/safe for conjoint couples therapy to resume.

When power and control dynamics are identified and couples therapy is discontinued, HIPPA confidentiality rules and regulations pertaining to individual confidentiality rights will be effective immediately.

I have read and understand this policy (please initial) _____

Court Testimony

My purpose is to provide professional, affordable counseling services to our community. It is my policy that I **do not** provide testimony in court for my clients, unless compelled by a court order to do so.

PRACTICES:

1. I will not testify on behalf of a client unless compelled to do so by court order. The client is responsible for all related fees if testimony is required.
2. I may provide a case summary to the client and the court, provided appropriate releases or court order is provided.
3. I have the right to refuse to treat a client who has the expressed objective of gaining a therapist's testimony in court.

I have read and understand this policy (please initial) _____

Termination:

Termination of counseling may occur at any time and may be initiated by either the client or the counselor. I request that if a decision to terminate is being made that the final session may be scheduled to explore the reasons for termination. Termination itself can be a constructive and useful process. If any referral is needed or requested, it will be made at that time.

I have read and understand this policy (please initial) _____

**I look forward to our work together and highly encourage your feedback as we collaborate on your specific therapeutic goals.

Instar Therapy Couple's Intake Form

Partner 1

Demographics

Name:_____ Date: _____

Address: _____ City:_____State:_____Zip:_____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: **Phone** or **Email** (circle one)

Age: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** (years married ____) **Divorced** **Widowed**

Children: Name Age

_____ _____

_____ _____

_____ _____

_____ _____

Referred by: _____

Previous Counseling

Previous Counseling? Yes No Who and When? _____

Release of information signed to talk with previous counselors? Yes No

Medical/Mental Health Information

What, if any, medical health problems do you have? _____

Physician _____ Current Medications _____

Are you on disability? ____ Please describe _____

Are you currently taking medication for a mental or emotional condition? _____

Please list conditions and medications: _____

_____

Have you ever been hospitalized for a mental or emotional condition? _____

If so, please list where and when: _____

_____

Do you currently use any alcohol or drugs? _____ If yes, what is your substance of choice?

_____

Are you in treatment? (such as outpatient) or utilizing support groups (such as AA)? _____

If yes, please describe: _____

What types of self-care practices have been helpful to you in the past when dealing with difficult situations? These may be things you learned from previous therapy or discovered on your own. Examples: journaling, exercising, workbooks, prayer, support groups -

_____

What are some of your hobbies/interests?_____

_____

Reasons for seeking counseling:

_____

_____

_____

_____

In a few words, what do you think therapy is all about?_____

_____

_____

How long do you think therapy should last?_____ How long are you able to commit to therapy?_____

What personal qualities do you think the ideal therapist should possess? _____

_____

Emergency contact information:

Name _____

Relationship: _____ **Phone:** _____

Client Signature: _____ **Date:** _____

Please describe your reason for seeking help		_____
❑ Yes	❑ No	Have you ever seen a counselor or mental health worker before?
		← Why were you seeking help?
❑ Yes	❑ No	← Was the counseling beneficial?
		← Who was the counselor?
❑ Yes	❑ No	Have you ever been hospitalized for any emotional or psychological difficulties?
		← What was the concern?
❑ Yes	❑ No	Does anyone in your family have emotional or psychological problems?
❑ Yes	❑ No	Is there anything currently bothering you or causing you to worry?
❑ Yes	❑ No	Are you having disturbances or difficulty with your sleep?
❑ Yes	❑ No	Have you experienced any changes in appetite recently?
❑ Yes	❑ No	Have there been any sudden changes with your weight?
❑ Yes	❑ No	Do you have any health problems (diabetes, heart problems, etc)?
❑ Yes	❑ No	Do you experience times when your heart races and you become short of breath?

❑ Yes	❑ No	Are you having headaches or migraines?
❑ Yes	❑ No	Are you experiencing any stomach problems?
❑ Yes	❑ No	Do you have any problems with depression?
❑ Yes	❑ No	Any suicidal thoughts or attempts? (past or present)
❑ Yes	❑ No	Do you have any unwanted thoughts that you cannot seem to get rid of?
❑ Yes	❑ No	Any problems related to thinking, concentrating, or memory?
❑ Short ❑ Medium ❑ Long		How would you rate your temper (fuse)?

Please answer the following questions so that I might have a better idea of how you are doing (circle the correct number):

	Not at all			Some			A lot
During the past week, how concerned or worried have you been about your health?	1	2	3	4	5	6	7
During the past week, how anxious, nervous, or tense have you been?	1	2	3	4	5	6	7
During the past week, how much have you been bothered by feelings of guilt?	1	2	3	4	5	6	7
During the past week, have you felt super-efficient or like you have unlimited energy, special talents or powers?	1	2	3	4	5	6	7
During the past week, how depressed have you felt?	1	2	3	4	5	6	7
During the past week, how irritable or angry have you been?	1	2	3	4	5	6	7
During the past week, how much distrust of others have you felt (or how much did it seem like others were out to hurt you)?	1	2	3	4	5	6	7
During the past week, did you hear or see things around you that others did not see?	1	2	3	4	5	6	7
During the past week, how much difficulty have you had with your thinking?	1	2	3	4	5	6	7

Instar Therapy Couple's Intake Form

Partner 2

Demographics

Name:_____ Date: _____

Address: _____ City:_____State:_____Zip:_____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: **Phone** or **Email** (circle one)

Age: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** (years married ____) **Divorced** **Widowed**

Children:	Name	Age
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Referred by: _____

Previous Counseling

Previous Counseling? Yes No Who and When? _____

Release of information signed to talk with previous counselors? Yes No

Medical/Mental Health Information

What, if any, medical health problems do you have? _____

Physician _____ Current Medications _____

Are you on disability? ____ Please describe _____

Are you currently taking medication for a mental or emotional condition? _____

Please list conditions and medications: _____

_____

Have you ever been hospitalized for a mental or emotional condition? _____

If so, please list where and when: _____

_____

Do you currently use any alcohol or drugs? _____ If yes, what is your substance of choice?

_____

Are you in treatment? (such as outpatient) or utilizing support groups (such as AA)? _____

If yes, please describe: _____

What types of self-care practices have been helpful to you in the past when dealing with difficult situations? These may be things you learned from previous therapy or discovered on your own. Examples: journaling, exercising, workbooks, prayer, support groups -

_____

What are some of your hobbies/interests?_____

_____

Reasons for seeking counseling:

_____

_____

_____

_____

In a few words, what do you think therapy is all about?_____

_____

_____

How long do you think therapy should last?_____ How long are you able to commit to therapy?_____

What personal qualities do you think the ideal therapist should possess? _____

_____

Emergency contact information:

Name _____

Relationship: _____ **Phone:** _____

Client Signature: _____ **Date:** _____

Please describe your reason for seeking help		_____ _____
❑ Yes	❑ No	Have you ever seen a counselor or mental health worker before?
		← Why were you seeking help?
❑ Yes	❑ No	← Was the counseling beneficial?
		← Who was the counselor?
❑ Yes	❑ No	Have you ever been hospitalized for any emotional or psychological difficulties?
		← What was the concern?
❑ Yes	❑ No	Does anyone in your family have emotional or psychological problems?
❑ Yes	❑ No	Is there anything currently bothering you or causing you to worry?
❑ Yes	❑ No	Are you having disturbances or difficulty with your sleep?
❑ Yes	❑ No	Have you experienced any changes in appetite recently?
❑ Yes	❑ No	Have there been any sudden changes with your weight?
❑ Yes	❑ No	Do you have any health problems (diabetes, heart problems, etc)?
❑ Yes	❑ No	Do you experience times when your heart races and you become short of breath?

❑ Yes	❑ No	Are you having headaches or migraines?
❑ Yes	❑ No	Are you experiencing any stomach problems?
❑ Yes	❑ No	Do you have any problems with depression?
❑ Yes	❑ No	Any suicidal thoughts or attempts? (past or present)
❑ Yes	❑ No	Do you have any unwanted thoughts that you cannot seem to get rid of?
❑ Yes	❑ No	Any problems related to thinking, concentrating, or memory?
❑ Short ❑ Medium ❑ Long		How would you rate your temper (fuse)?

Please answer the following questions so that I might have a better idea of how you are doing (circle the correct number):

	Not at all			Some			A lot
During the past week, how concerned or worried have you been about your health?	1	2	3	4	5	6	7
During the past week, how anxious, nervous, or tense have you been?	1	2	3	4	5	6	7
During the past week, how much have you been bothered by feelings of guilt?	1	2	3	4	5	6	7
During the past week, have you felt super-efficient or like you have unlimited energy, special talents or powers?	1	2	3	4	5	6	7
During the past week, how depressed have you felt?	1	2	3	4	5	6	7
During the past week, how irritable or angry have you been?	1	2	3	4	5	6	7
During the past week, how much distrust of others have you felt (or how much did it seem like others were out to hurt you)?	1	2	3	4	5	6	7
During the past week, did you hear or see things around you that others did not see?	1	2	3	4	5	6	7
During the past week, how much difficulty have you had with your thinking?	1	2	3	4	5	6	7

Notice of HIPPA Privacy Practices

We are required by law to follow the practices described in this letter. This letter is a summary of our Privacy Practices, but does not replace the full version which has been made available to you. This notice applies to personal medical/mental health information that we have about you, and which are kept in or by this facility. With some exceptions, we must obtain your authorization to disclose (or release) your health care information. There are some situations in which we do not have to obtain your authorization. We can use your protected health information and share it with members of our organized health care arrangement (like a community provider). Neither this pamphlet nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Office for this facility.

Who Has Access To Your Personal Information?
Medical/Mental health information about you can be used to:

- Plan your treatment and services. This includes releasing information to qualified professionals who work at our facility and are involved in your care or treatment. It may also include provider agencies whom we pay to provide services for you. We will only release as little as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third party payers.
- Obtain approval in advance from your insurance company.
- Exchange information with Social Security, Employment Security, or Social
- Services.
- Measure our quality of services.
- Decide if we should offer more or fewer service to clients.

Without your permission, we may use your personal information:

- To exchange information with other State agencies as required by law.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To inform you about possible treatment options.
- To send you appointment reminders.
- For agencies involved in a disaster situation.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- As required by State, Federal or local law. This includes investigations, audits, inspections, and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To communicate with coroner, medical examiners and funeral homes when necessary for them to do their jobs.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with a correctional facility if you are an inmate.

What Are Your Rights?

- To see and get a copy of your record (with some exceptions).
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete.
- You must make this request in writing. We may deny your request if:
    1. We did not create the entry
    2. The information is not part of the file we keep; or
    3. The information is not part of the file that we would let you see; or
    4. We believe the record is accurate and complete.

- To know to whom we have sent information about you for up to the last six years.
- The first request in a 12 month period is free. We may charge you for additional requests.
- To limit how we use or disclose information about you. For example-not to release information to your spouse or a particular provider agency. This must be made in writing, and we are not required to agree to the request.
- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To tell us (authorize) other released of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).

Kristen Maloney, LMFT

Instar Therapy

Acknowledgement of Receipt of Counseling Policies
& Informed Consent And Notice of Privacy Practices
(Please print and return with additional paperwork)

Welcome! I look forward to our work together, and anticipate that it will be a very positive and beneficial experience. This information as well as the notice to privacy information has been provided to inform you of the parameters of care I provide. It is my desire, as I join you in this process, to work toward seeing your desired goals achieved. However, therapeutic care offers no absolute guarantee of success and there are limitations to any form of care offered to a client. If you have any questions or concerns please feel free to share them with me.

I have received and read Kristen Maloney,LMFT's **Counseling Policies and Informed Consent and HIPPA Privacy Practices**. I agree to the policies set forth in these documents and understand what they entail.

Your signature acknowledges your informed consent to care.

_____ _____
Signature (Client) Date

_____ _____
Signature (Client) Date

_____ _____
Kristen Maloney, LMFT Date

Kristen Maloney, LMFT

Instar Therapy

Credit Card Authorization

Client Name: _____

Name on Credit Card (if different from client): _____

Fee (per session): $_____ +$2.00 =$_____(total to be charged to card)

Method of Payment: _____ Visa _____ MasterCard _____ Discover

Card #: _____

Exp. Date: _____ CVC Code: _____

Billing address (must match the address the credit card company has on file):

_____

_____

I authorize Kristen Maloney, LMFT to keep my credit card information confidentially filed with my session records to use as payment for each of my sessions unless other form of payment is provided or requested. I understand I must provide cash or check should my credit card be declined.

Signature: **_____**

Date: **_____** ***Phone Number:*** **_____**

Kristen Maloney, LMFT

Instar Therapy
Sliding Scale Information and Application

Sliding rates are offered to a maximum number of clients per month. Applications may not be accepted if space is limited.

The fee for all types of counseling services is $85 per clinical hour (50 min). You may apply for a sliding scale fee if your household gross income is under $65,000 per year. These fees are granted to a limited number of applicants due to scheduling availability. If you qualify, charges per session are as follows:

66K and above - $85
56K – 65K - $80
46K – 55K - $70
Under 45K - $60

In order to apply, please verify your gross household income by submitting a recent pay stub (for you and spouse if applicable) or a copy of your w-2.

Name of person responsible for payment_____

Occupation/Employer of person responsible for payment (and spouse if applicable):
_____
_____

Please provide GROSS annual amounts for the following income categories:

Salary 1 _____

Salary 2 _____

Social Security income _____

Disability income _____

Additional Resources used to cover expenses _____

Total household income _____

I certify the above information is correct. I will notify Kristen Maloney, LMFT of any changes in my household income that would affect my use of sliding scale.

Signature:_____**Date:**_____ _____