Client Name _____

_____

Medicaid # _____

INTAKE

Joseph Tooley, PhD LPP
455 Swiftside Drive, Suite 102 Cary, North Carolina 27518
Phone: (919) 656-0950 Fax: (984) 200-9817
eMail: JoeTooley@TooleyGroup.com

Welcome to the Tooley Group!

I look forward to our work together as a time of learning and positive growth for you and your family.

RIGHT TO TREATMENT AND ACCESS TO YOUR TREATMENT PLAN

You have the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability. You have the right to receive a copy of your Treatment Plan at any time. Please request a copy in writing and I will deliver them to you as you request in person or by mail.

AVAILABILITY

Once we agree to work together in psychotherapy, I am available 24 hours a day. I am available to conduct therapy sessions by Zoom depending on your circumstances. To reach me, call 919-656-0950. Leave a voice message if I do not answer. I will respond as soon as possible unless I am meeting with other clients or I do not have access to my cell phone (e.g. at a movie). If I am unavailable (out of the country) my voice message will indicate the person who is covering my practice.

MY EXPECTATIONS FOR OUR WORK TOGETHER

Fees for Services

All services, including individual, marital and family therapy and school consultations are $170.00 per session. Fees are payable in full each session and may be paid by check (payable to the "Tooley Group"), American Express, MasterCard, Visa, or cash. Irrespective of insurance, you are financially responsible for services rendered.

Appointments

I appreciate you being on time for your therapy session or notifying me by text or telephone call at 919-656-0950 if you will be late for that session. I request 24 hours' notice if you cannot make an appointment you have scheduled. If you miss two consecutive sessions without notifying me, I will wait to schedule another appointment until we have talked.

Therapy sessions will typically last fifty minutes. Since the problems that brought you to therapy are unique and every session has its own pace, some sessions may be longer or shorter than others. The goal is to complete the therapy work, not fill a fifty-minute hour.

INSURANCE/PPO

I am an out-of-network provider with all commercial insurance companies. You remain responsible for payment of all fees whether reimbursement is made or denied by your insurance carrier or PPO. I will file a claim with your insurance company as a courtesy. Since I cannot say how much it will reimburse you, I suggest you contact your insurance company to determine your coverage.

ACCESS TO POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

Please sign: _____ Date: _____

I have had access to the Notice of Policies and Practices to Protect the Privacy of Your Health Information provided by Joe Tooley PhD Psychologist, LPP.

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CONFIDENTIALITY

All information that we share is confidential and the confidentiality is upheld at all time. However, there are certain exceptions to this rule:

1. If you request that information be released as stated and signed in the "Authorization to Release or Request Treatment Notes."
2. If I believe you intend to harm yourself or another person.
3. The law requires that all suspected child or elder abuse or neglect be reported to the appropriate agency.
4. In legal proceedings, client/counselor information is privileged except when mental status is an issue or if the judge declares the information necessary for the administration of justice.
5. I am allowed to release confidential information in required emergency treatment, a request from a funding source or an audit. My working with you is not contingent upon such consent and of the need for such release. I understand you give this consent voluntarily.
6. Confidential information may not be disclosed without written consent when federal statutes prohibit that release.

CONSENTS

I understand/consent to the following (strike through all that does not apply):

1. I have legal custody of my child(ren) _____.
2. I consent to my children being seen in psychotherapy by Joe Tooley PhD, Psychologist LPP.
3. I consent to seeing Dr. Tooley in mental health treatment including access to medical care and habilitation, regardless of age of degree of disability.
4. I consent to Dr. Tooley seeking emergency room care from a hospital or physician if necessary.
5. I consent to Dr. Tooley talking to my own physician or my children's physician concerning personal health information when needed without specific written permission for each communication.
6. I will receive a copy of the Individualized Treatment Plan within fifteen days of my first therapy session.
7. I have the right to contact Disability Rights North Carolina at 2626 Glenwood Avenue, Raleigh NC 27608. Telephone 919-856-2195
8. I have the right to refuse treatment without threat or termination of services.
9. My consent for treatment may be withdrawn at any time.
10. I understand I have a right to receive a copy of my treatment record whenever I ask for one in writing.

COMPLAINT PROCEDURES

If you are dissatisfied about our work together please let me know.
You may also inform the North Carolina Board of Psychologists of your concerns:
North Carolina Board of Psychologists, 895 State Farm Road, Suite 101, Boone NC 28607, 828-262-2258.

I have read these policies and understand and accept the policies as described.

Signature: _____ **Date:** _____

Intake signed by Joe Tooley PhD, Psychologist LPP

Signature: _____ **Date:** _____

Client Name _____

_____

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eMail: JoeTooley@TooleyGroup.com

Date: _____

INTAKE INFORMATION

ADULT/PARENT INFORMATION: (Yourself)

Name_____
Gender M F
Address_____
City_____State ___ Zip_____
Phone: Cell_____
Home_____
Work _____
DOB_____ Age _____
Education_____
Employer_____
Physician_____
Medications_____
Allergies_NKA_____
Religion_____
E-mail_____

(Your spouse/partner)

Name_____
Gender M F
Address_____
City _____ State ____ Zip_____
Phone: Cell _____
Home _____
Work _____
DOB_____ Age_____
Education_____
Employer_____
Physician _____
Medications_____
Allergies_NKA_____
Religion_____
E-mail_____

How long have you been married/together?_____
Have you been in therapy before? _____ With whom and where? _____
Why are you here? _____
Who referred you? _____

CHILD INFORMATION:

Children's

Names	Gender	Age	DOB	School	Grade	Teacher	Allergies	Medications

Children's Doctor _____ Phone _____ Fax _____

Address _____ City_____ State_____ Zip _____

Your Emergency Contact Name _____ Phone _____

Address _____ City_____ State_____ Zip _____