BECK'S DEPRESSION INVENTORY

Instructions: Please circle the number by the response for each question that best describes how you have felt during the past seven (7) days. Please do not omit any questions. Make sure you check one answer for each question. If more than one answer applies to how you have been feeling, check the higher number. If in doubt, make your best guess.

1. 0 - I do not feel sad.
   1 - I feel sad.
   2 - I am sad all the time and I can't snap out of it.
   3 - I am so sad or unhappy that I can't stand it.

2. 0 - I am not particularly discouraged about the future.
   1 - I feel discouraged about the future.
   2 - I feel I have nothing to look forward to.
   3 - I feel that the future is hopeless and that things cannot improve.

3. 0 - I do not feel like a failure.
   1 - I feel I have failed more than the average person.
   2 - As I look back on my life, all I can see is a lot of failures.
   3 - I feel I am a complete failure as a person.

4. 0 - I get as much satisfaction out of things as I used to.
   1 - I don't enjoy things the way I used to.
   2 - I don't get real satisfaction out of anything anymore.
   3 - I am dissatisfied or bored with everything.

5. 0 - I don't feel particularly guilty.
   1 - I feel guilty a good part of the time.
   2 - I feel quite guilty most of the time.
   3 - I feel guilty all of the time.

6. 0 - I don't feel I am being punished.
   1 - I feel I may be punished.
   2 - I expect to be punished.
   3 - I hate myself.

7. 0 - I don't feel disappointed in myself.
   1 - I am disappointed in myself.
   2 - I am disgusted with myself.
   3 - I hate myself.

8. 0 - I don't feel I am any worse than anybody else.
   1 - I am critical of myself for my weaknesses or mistakes.
   2 - I blame myself all the time for my faults.
   3 - I blame myself for everything bad that happens.

9. 0 - I don't have any thoughts of killing myself.
   1 - I have thoughts of killing myself, but I would not carry them out.
   2 - I would like to kill myself.
   3 - I would kill myself if I had the chance.

10. 0 - I don't cry any more than usual.
    1 - I cry more now than I used to.
    2 - I cry all the time now.
    3 - I used to be able to cry, but now I can't cry even though I want to.

Turn The Page Over

11. 0 - I am no more irritated by things than I ever am.
1 - I am slightly more irritated now than usual.
2 - I am quite annoyed or irritated a good deal of the time.
3 - I feel irritated all the time now.

12. 0 - I have not lost interest in other people.
1 - I am less interested in other people than I used to be.
2 - I have lost most of my interest in other people.
3 - I have lost all of my interest in other people.

13. 0 - I make decisions about as well as I ever could.
1 - I put off making decisions more than I used to.
2 - I have greater difficulty in making decisions than before.
3 - I can't make decisions at all anymore.

14. 0 - I don't feel that I look any worse than I used to.
1 - I am worried that I am looking old or unattractive.
2 - I feel that there are permanent changes in my appearance that make me look unattractive.
3 - I believe that I look ugly.

15. 0 - I can work about as well as before.
1 - It takes an extra effort to get started at doing something.
2 - I have to push myself very hard to do anything.
3 - I can't do any work at all.

16. 0 - I can sleep as well as usual.
1 - I don't sleep as well as I used to.
2 - I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 - I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 - I don't get more tired than usual.
1 - I get tired more easily than I used to.
2 - I get tired from doing almost anything.
3 - I am too tired to do anything.

18. 0 - My appetite is no worse than usual.
1 - My appetite is not as good as it used to be.
2 - My appetite is much worse now.
3 - I have no appetite at all anymore.

19. 0 - I haven't lost or gained much weight, if any, lately.
1 - I have lost or gained more than five pounds.
2 - I have lost or gained more than ten pounds.
3 - I have lost or gained more that fifteen pounds.

20. 0 - I am no more worried about my health than usual.
1 - I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
2 - I am very worried about physical problems and it's hard to think of much else.
3 - I am so worried about my physical problems that I cannot think of anything else.

21. 0 - I have not noticed any recent change in my interest in sex.
1 - I am less interested in sex than I used to be.
2 - I am much less interested in sex now.
3 - I have lost interest in sex completely.

Name_____**Date**_____**Total**_____

1-10 Normal; 11-16 Mild;17+ Clinical Depression:17-20 Borderline, 21-30 Moderate, 31-40 Severe, 41+ Extreme

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .

Interpretation

A grand sum between **0 – 21** indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to "mask" the symptoms commonly associated with anxiety. Too little "anxiety" could indicate that you are detached from yourself, others, or your environment.

A grand sum between ***22 – 35*** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not "panic" time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a physician or counselor if the feelings persist.

Part 1

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

PLEASE COMPLETE PART 2 ON THE FOLLOWING PAGE

Part 2:

A. If you checked anything for #17 in PART 1, briefly identify the event you were thinking of:

_____

_____

B. If you have experienced more than one of the events in PART 1, think about the event you consider the worst event, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event (check all options that apply):

1. Briefly describe the worst event (for example, what happened, who was involved, etc.).

   _____

   _____

2. How long ago did it happen? _____ (please estimate if you are not sure)

3. How did you experience it?
   - _____ It happened to me directly
   - _____ I witnessed it
   - _____ I learned about it happening to a close family member or close friend
   - _____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
   - _____ Other, please describe: _____

4. Was someone's life in danger?
   - _____ Yes, my life
   - _____ Yes, someone else's life
   - _____ No

5. Was someone seriously injured or killed?
   - _____ Yes, I was seriously injured
   - _____ Yes, someone else was seriously injured or killed
   - _____ No

6. Did it involve sexual violence? _____Yes _____No

7. If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?
   - _____ Accident or violence
   - _____ Natural causes
   - _____ Not applicable (The event did not involve the death of a close family member or close friend)

8. How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?
   - _____ Just once
   - _____ More than once (please specify or estimate the total # of times you have had this experience _____)

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

PTSD CheckList – Civilian Version (PCL-C)

The PCL is a standardized self-report rating scale for PTSD comprising 17 items that correspond to the key symptoms of PTSD. Two versions of the PCL exist: 1) PCL-M is specific to PTSD caused by military experiences and 2) PCL-C is applied generally to any traumatic event.

The PCL can be easily modified to fit specific time frames or events. For example, instead of asking about "the past month," questions may ask about "the past week" or be modified to focus on events specific to a deployment.

How is the PCL completed?

 The PCL is self-administered

 Respondents indicate how much they have been bothered by a symptom over the past month using a 5-point (1–5) scale, circling their responses. Responses range from **1** *Not at All* – **5** *Extremely*

How is the PCL Scored?

1) Add up all items for a total severity score
or
2) Treat response categories **3–5** (*Moderately* or above) as symptomatic and responses **1–2** (below *Moderately*) as non-symptomatic, then use the following DSM criteria for a diagnosis:
- Symptomatic response to at least 1 "B" item (Questions 1–5),
- Symptomatic response to at least 3 "C" items (Questions 6–12), and
- Symptomatic response to at least 2 "D" items (Questions 13–17)

Are Results Valid and Reliable?

 Two studies of both Vietnam and Persian Gulf theater veterans show that the PCL is both valid and reliable (Additional references are available from the DHCC)

What Additional Follow-up is Available?

 All military health system beneficiaries with health concerns they believe are deployment-related are encouraged to seek medical care

 Patients should be asked, **"Is your health concern today related to a deployment?"** during all primary care visits.

• If the patient replies "**yes**," the provider should follow the Post-Deployment Health Clinical Practice Guideline (PDH-CPG) and supporting guidelines available through the DHCC and www.PDHealth.mil

Client Disclosure Statement

(Information and Consent for Treatment)

I am pleased that you have chosen RDU Counseling for Change for your counseling. This document is designed to inform you about our services offered, session fees and length, nature of our professional relationship, and document your understanding of and consent to treatment.

Counseling Services Offered

You can get the most out of our time together if you understand how counseling works and something about how I practice. I view counseling as a collaborative experience and a safe place where you can explore your thoughts, feelings, and behaviors in a non-judgmental atmosphere. I will listen, help you clarify your thoughts and feelings, and help you begin to gain a better understanding of yourself. Counseling is based on the development of a trusting relationship between us and the development of goals for your situation and plans to accomplish them. These goals will be your goals and will need to be realistic ones towards which you can work. I will encourage, support, and help you devise appropriate steps to move closer to your goals. Thus, counseling will include your active involvement and efforts to understand and change your thoughts, feelings, and behaviors. You will have to work both in and out of counseling sessions. Some steps may include homework assignments, exercises, writing in a journal, or observing yourself and practicing new behaviors.

RDU Counseling for Change provides therapy for individuals (age 12+), couples, and families in the following areas: depression, anxiety, mood disorders, grief and loss, adjustment difficulties, trauma, abuse, stress management, communication skills, spiritual issues, women's issues, relationship issues, couples, and family therapy. We do not work with people whom, in our professional opinion, we cannot help using the resources and skills I have available, and will in such cases offer referrals to another therapist who may be better equipped to help.

With respect to our theoretical basis for counseling, we use an eclectic style pulling from the following approaches based on your goals and situation: Eye Movement Desensitization and Reprocessing (EMDR) Therapy, Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Acceptance and Commitment Therapy, Psychodynamic, Solution-Focused, and Motivational Interviewing when working with individuals, as well as Emotionally Focused Therapy (EFT), Structural Family Therapy, and Family Systems Theory with couples and families.

We also believe that we are whole persons with physical, psychological, social, and spiritual parts. All of these parts play a role in how we encounter the world and relate to others. That is why RDU Counseling for Change believes counseling is a safe place to explore matters of faith. As Christians, we are committed to an approach that includes an integration of our Christian faith with compatible psychological perspectives. But whether we include discussion of the spiritual dimension of life in our time together will be up to you. If you are interested in integrating a spiritual discussion into our sessions, please let your therapist know. However, it is important that you understand that our faith informs who we are, how we understand others, and the nature of and solutions for problems in living. Primarily, we believe that each person has innate value and worth, deserving to be treated with respect and value.

We will enter our relationship with hope and expectation for positive change. It is important, however, that you understand there are possible risks as well as benefits of counseling. Risks might include uncomfortable levels of feelings like sadness, guilt, anxiety, anger or frustration, or you may experience difficulties with others. Sometimes, relationships can take unaccustomed directions that feel quite awkward at first. That initial awkwardness can occur no matter how you evaluate the balance between the long-term costs and benefits compared to the old ways of relating. Decisions you make regarding these areas of your life will remain your responsibility.

We may refer you to other professionals, such as doctors, nutritionists, or other supportive services if we feel that you would benefit from additional resources. RDU Counseling for Change believes in a collaborative approach and would request you to fill out a release of information form, so that we may consult with these other professionals. You may, as with all aspects of your treatment, decline such recommendations. The process of ending therapy, called "termination," can be a very valuable part of our work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is in your best interest. If you wish to stop therapy, we ask that you agree now to meet then for at least one session to review our work together. We will review our goals, the work we have done, any future work that needs to be done, as well as our choices.

Sessions

We assure you that our services will be provided in a professional manner and will be consistent with accepted ethical standards. Sessions are about 50-55 minutes in duration. We will decide together on the frequency and appointment times of sessions, which are generally weekly to biweekly. You are responsible for your regular appointment hour, and I reserve this time for you. Please provide me with 48 hours' notice if you need to change your appointment. Otherwise, you will be charged the entire fee for your session.

Fees

Our per-session fee is $130 for therapy and $150 for the initial session. We contract with Blue Cross Blue Shield of North Carolina (with the exception of Blue Value, Blue Local, and Blue Medicare), Cigna, Aetna, and Tricare insurances and will bill for these visits. For other health insurance companies, we are considered out-of-network. If you choose to work with us, we will provide you with a Super Bill for you to submit for reimbursement. If you choose to file for reimbursement from your insurance company, they may require information regarding diagnosis, symptoms, treatment goals, and methods. Any diagnosis provided to your insurance company becomes a part of your permanent medical record.

If you anticipate difficulty with payment, please discuss your concerns with us. Fees for counseling services are due at the end of each session. Cash, personal check, or credit card is accepted.

Confidentiality

We regard the information you share with me with the greatest respect, so we want us to be as clear as possible about how it will be handled. All information that we share, as well as my records of our conversations, are confidential. There are four circumstances in which I cannot guarantee confidentiality, either legally or ethically:

(1) If the therapist believes that the client is in a clear and imminent danger to self or others, I will contact the appropriate authorities to prevent harm. I would explore all other options with you before taking this step. However, if at that point you were unwilling to take steps to guarantee your safety, I would call the police.

(2) If child, elder, or dependent/impaired adult abuse is suspected, the law requires I report it to the appropriate authorities.
(3) If you give me written permission to disclose your information.
(4) In rare circumstances, therapists can be ordered by a judge to release information.
(5) In case of a medical emergency.
(6) If you use your medical insurance, your insurance company may inquire about your therapy. No information other than your diagnosis and date of service will be provided without a written consent for Release of Information from you. Please be aware that I cannot control how your insurance company uses information about you, and/or your dependent(s) once it is in their possession.

In order to provide you with the best possible help, we will consult with colleagues and other therapists who may have insights that will be of assistance, but only in such a way that your confidentiality is preserved.

Consultation
During the course of treatment, consultation may be a required and/or a necessary part of your care. If a court appearance is required, a minimum rate of $250 will be retained for such service. Each subsequent hour, including such actions as time spent in travel, preparation, document preparation, and consultation with attorneys or other professionals will be billed at a rate of $150 per hour. Payment for such will be required on the date of service. Time spent in phone consultation or attendance at school conferences, such as IEP meetings, will be billed at $150 an hour.

Communication
With the advancement of technology, it is important to be mindful of the possible implications of texting or e-mailing with one another. Our primary mode of communication needs to be in the context of the therapy room. We do our best to return phone calls within 24 hours, except for weekends or vacations. Do not text or email if in crisis. Please call 911 or visit your local emergency room. In the event that e-mail is exchanged (e.g., intake documents), RDU Counseling for Change will use our secure online portal of Jituzu to ensure the confidentiality of our communication. Please use this portal as well for all e-mails. Emails should not be used in place of therapy. If you e-mail, we will discuss the contents at session.

Explanation of Dual Relationships
Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to the sessions you arrange with me. You will be best served while I am seeing you for counseling if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You may learn more about me as we work together, but it is important for you to remember that you are experiencing me as a professional therapist.

Complaint Procedures
If you are dissatisfied with any aspect of our work, this is most effectively and productively dealt with in our sessions together. Please feel free to ask any questions or clarify any confusion you may have about our work. If you think that you have been treated unfairly or unethically by me and cannot resolve this problem with me, you can contact the North Carolina Board of Marriage and Family Therapists at P.O. Box 5549, Cary, NC 27512 or the North Carolina Board of Licensed Professional Counselors at P.O. Box 77819, Greensboro, NC 27417.

Please read carefully and complete the following section:

By signing below, you are acknowledging the following:

- I have read these policies and understand and accept them as described.
- I hereby give my permission and consent to RDU Counseling for Change to provide psychotherapeutic treatment to me and/or _____ who is (are) my spouse/child(ren).
- I understand that I need to give 48 hours' notice of an appointment change or will be responsible for my per session rate.
- I will pay $130 per session or copay required by insurance, as agreed upon with the therapist.

Client's Signature_____Date _____

Client's Signature_____Date _____

Therapist's Signature _____Date _____

Client Demographics

_____

First Name MI Last Name

DOB: _____ Social Security #: _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Preferred Method of Contact for Appointments: ☐ **phone** ☐ **email**

Referring Physician: _____

Medications: _____

Gender: ☐Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Legally Separated

☐ Widowed ☐ Domestic Partner ☐ Unknown

Race (Optional): ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ _____

Employment Status: ☐ Unemployed ☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Student

Employer: _____

If seeking a sliding scale fee, please list your annual income: _____

RESPONSIBLE PARTY (Person Responsible for Payment of Charges. If same as client, **write SELF** and go to next section.)

_____

First Name MI Last Name

Relationship to Client: _____ Social Security #: _____

DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

1. **Have you ever received psychological, psychiatric, alcohol or drug treatment before?**
   Yes No If yes, please describe in detail:

_____
_____
_____
_____

2. **Have you ever been prescribed medications for psychiatric or emotional problems?**
   Yes No If yes, please describe in detail:

_____
_____
_____
_____

3. **Please list any psychiatric or substance abuse hospitalization/s (include dates of treatment):**

_____
_____
_____
_____

4. **Do you have a family history of mental illness or substance abuse? If so, please explain.**

_____
_____
_____
_____

5. **Please provide the name of your primary care physician:**_____
   _____
   Phone Number Address City Zip

   May RDU Counseling for Change contact your primary care physician to coordinate your care?

   Yes No

6. **Please list any current medical/health-related conditions, or concerns:** _____

_____
_____
_____
_____

7. **Please list any current medications (include name of doctor prescribing medication and any over the counter medications or herbal remedies):** _____

_____
_____
_____
_____

8. **Are you experiencing dissatisfaction or difficulties with your sex life? Yes No**
9. **Do you have any current legal charges, court involvement or under court order to receive services?**
   If yes, please describe:

_____
_____
_____

PLEASE CHECK ALL THAT APPLY:

	Headaches		Memory problems		Depression
	Sleep problems		Heart palpitations		Feeling tense or nervous
	Academic concerns		Ideas of harming yourself		Drug use
	Worries about money		Feeling shy around others		Not confident
	Having a lack of friends		Stomach problems		Concerned about eating habits
	Feelings of panic, fear, phobias		Trouble concentrating		Alcohol use
	Feeling sad or depressed		Grief or loss		Nightmares
	Feeling restless		Feelings of hopelessness		Feelings of worthlessness
	Low self-esteem		Disturbing thoughts		Hallucinations
	Aggression		Mood swings		Recurring thoughts
	Chest pain		Suicidal thoughts		Trembling
	Sexual concerns		Sexual identity concerns		Anger
	Ideas of harming others		Memory problems		Chronic pain
	Blaming or criticizing self		Abusing others		Dizziness
	Feeling tired		Feeling a need to be on the go		Problems at work
	Anxiety		Antisocial or illegal behavior		Concerned about family members
	Irritability		Abused by others		Sick often
	Isolating self		Disorganized thoughts		Relationship problems
	Distractibility		Impulsive		Poor judgment

Please add any other information that would be helpful for the counselor to know.

_____

_____

_____

_____

Emergency Contact (Please complete)

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you —perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about your harming someone else. Please write down the name and contact information for your emergency contact person.

Name: _____ Relationship to you: _____

Phone Number: _____ Address: _____

City Zip

E-Mail Address: _____

Acknowledgement Page

Please read each statement and initial that you have received and understand the information given.

_____ **Acknowledgement of Receipt of Written Statement of Clients' Rights.** I have received and reviewed a copy of Kelly Harrison's Statement of Clients' Rights explaining my rights.

_____**Verification of Receipt of Privacy Notice.** I have received and reviewed a copy of Kelly Harrison's Privacy Notice explaining how my Protected Health Information (PHI) will be protected and under what conditions this information will be released.

_____**Acknowledgement of Receipt of Consent to Treatment.** I declare that I am legally competent and that I have the capacity to consent to my treatment and/or to the treatment of family members of whom I am the parent or guardian.

_____**Acknowledgement of Receipt of Payment and Attendance Policies.** I understand that I will be charged my entire fee if I miss an appointment or did not cancel 48 hours in advance. Insurance will not cover missed appointments.

I am responsible for the copay/coinsurance/fee at the time of service or within one week of received service.

_____ **Consent to use email and text for communication.** Email, text messaging, and other forms of electronic communication are not secure or protected. However, I understand the social necessity for these types of communication. Please be advised that telephone calls are the best form of communication, but that text messages and emails will be used with your acknowledgement.

_____**Termination of Services.** I understand that after the third missed appointment I may be contacted and notified of the termination of services.

Client Name (print):_____

Client Signature: _____ Date: _____

Witnessed by: _____ Date: _____

Financial Agreement

Primary Insurance Information

Insurance Company | Insurance Telephone

Policy ID Number | Group Number

Policyholder Name

Address | City, State, ZIP

Telephone | Social Security Number

Policyholder's Date of Birth | Sex: ☐ M ☐ F

Relationship of patient ☐ Self ☐ Spouse to policyholder ☐ Dependent

☐ Other

Start Date of Coverage _____ Co-pay _____

Consent to Release Information

I **authorize** any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, peer-review organization, insurance or reinsuring company, the Health Care Financing Administration, the Medical Information Bureau, Inc., consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to give the group policyholder, my employer, third-party administrator, my third-party carrier or its legal representative, any and all such information.

I **understand** the information obtained by this authorization will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim or claims submitted by Kelly Harrison C ounseling PLLC or as may be otherwise lawfully required or as I may further authorize. I also **authorize** that payment of medical benefits be made to the physician or organization listed on any claim submitted for any services furnished me by that physician or organization or to an agent contracted by Kelly Harrison as agent for that physician or organization, as directed by the physician or organization.

I agree that these authorizations shall be valid until rescinded in writing or replaced at a later date.

Client Signature (or Legal Guardian if client is a minor) Date

Credit Card Authorization Form

Name: _____ **Date:** _____

I authorize Kelly Harrison Counseling to charge my credit card for the full amount of each counseling session or my copay. I also authorize Kelly Harrison Counseling to charge my credit card for the $75 No-Show Fee if I fail to cancel my appointment within 24 hours.

I understand that it is my responsibility to keep an updated copy of my credit card information on file. If my credit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check.

Name as it appears on Card: _____

☐ MasterCard ☐ Visa ☐ Discover Card ☐ American Express

Credit Card #: _____ Expiration Date: _____

CCV: _____ Billing Address/Zipcode: _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

_____ _____

Client Signature Date

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Instruction F: Insert Effective Date of Notice here.

This Notice of Privacy Practices applies to the following organizations.