LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee of is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency**.** A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Preferred Pronouns:

Name: _____ _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) - May we leave a msg? □Yes □No

Cell/Other Phone: ( ) - May we leave a msg? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please be aware that email might not be confidential.

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □Yes □No

Have you had previous psychotherapy?
□No
□Yes, at Previous therapist's name_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes
□No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?
□Yes □No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

7. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?
□ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:

_____

Have you ever experienced:

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no

Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member**
Depression	yes/no
Bipolar Disorder	yes/no
Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no

Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

PSYCHOTHERAPY ASSESSMENT CHECKLIST (1/01)

Psychotherapy Research Program at HMS, Leigh McCullough Ph.D.

PERSONAL DATA

Name _____ **Date** _____

Address _____ **Age** _____ **DOB** ____/____/____ **Sex M F**

_____ **Home Phone (____)** _____

_____ **Occupation** _____

_____ **Work Phone (____)** _____

No. Years Education _____ **Marital Status** _____ **Insurance Co.** _____

Currently living with _____ **Ins. Group #** _____

Spouse/Partner's Occupation _____ **No. of Children** _____ **Ages** _____

Person to contact in an emergency _____ **Phone (____)** _____

Address _____ **Relation to you** _____

MAIN PROBLEMS: Please list the major problems that you would like help with in therapy, and rate the severity of each one according to the scale below:

1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 --------- 10

Not a Problem Mild Problem Moderate Problem Severe Problem Couldn't be worse **RATING**

1._____ _____

2._____ _____

3._____ _____

Briefly describe what motivated you to seek therapy <u>at this time</u> (rather than some time earlier or later): _____

_____

(Please use the back of this page or an additional sheet of paper if you need extra space for answers)

(Axis III) MEDICAL PROBLEMS: Do you have any serious medical conditions? (If yes, please describe)..... No Yes

_____

Problems with: Headaches___ Indigestion___ Diarrhea ___ Constipation___ Circulation ___ Shortness of Breath ___ Frequent Urination ___

Body Aches/ Pain ___ Menstrual problems ___ **How would you rate your overall health? Excellent ___ Good ___ Fair ___Poor___**

Please list any medications you are taking:_____

In Past Year, how many: Visits to doctor____ Sick days____ Cigarettes-day ____ Alcoholic drinks/day _____ Psychotherapy sessions,**ever**____

Number of family members with: Alcohol/drug problems ___ Psychiatric problems (e.g., depression, psychosis) _____

(Axis IV) CURRENT STRESSFUL EVENTS: Legal ___ Financial ___ Family problems ___ Family Illness ___

Other _____ **Are you in an abusive relationship?** No__ Somewhat__ Yes__

Recent losses (jobs, relationships, or difficult changes)_____

Axis V: Self -Report of Assessment of Functioning **Initials _____**

DAILY FUNCTIONING: Please give a rough estimate of how many <u>hours per week</u> you spend doing the following <u>in a typical week</u>:

Working in your primary job ..... ____
Parenting/Caretaking of others ..... ____
Doing household chores, bills, etc ..... ____
TV, Movies ..... ____
Physical recreation or exercise of some kind ..... ____
Hobbies (crafts, games, music, dancing, reading, etc.)____
Social activity with friends, family ..... ____
Church, charity, spiritual or inspirational activities ... ____
Quiet, non-productive, or relaxing time ..... ____
Average number of hours of sleep <u>per night</u> ..... ____

LIFELONG FUNCTIONING: Please check the best and worst times of your life:

Age	Best Times	Average times	Worst Times
0-5	_____	_____	_____
6-12	_____	_____	_____
13-19	_____	_____	_____
20-29	_____	_____	_____
30-39	_____	_____	_____
40-49	_____	_____	_____
50-59	_____	_____	_____
60-69	_____	_____	_____
70-79+	_____	_____	_____

WORST TIME IN LIFE (Please briefly describe). (You may use the back of this page for answers in the following sections, if needed:)

_____

_____

Who helped you through it?_____

Are there things that cause you to feel ashamed or that would be difficult to talk about? (No need to specify) ..... No Yes

BEST TIME IN LIFE (Please briefly describe)_____

_____

_____ Was there someone to share it with? Yes No

Do you have a close friend who is supportive and someone you can confide in during difficult times?.....Yes No

What have you done that you are **MOST PROUD OF?** _____

_____

What are your **STRENGTHS** (How do you cope) when times are hard? _____

_____

Do you feel you are a person of worth at least on an equal basis with others? VeryMuch Much Somewhat A little No

How much enjoyment or pleasure are you currently getting out of living? VeryMuch Much Moderate A little None

What is your income range? Under $20,000___ /$20-39,000___ /$40-59,000___ /$60-80,000___ / Over $80,000___

(Axis V) SELF-ASSESSMENT OF FUNCTIONING: Please rate (from 1-10) how well you feel you are <u>currently</u> functioning in each of the three areas listed below, according the following scale:

10 ------- 9 -------- 8 --------7-------- 6 -------- 5 --------4---------3 -------- 2 -------- 1

Excellent Functioning Mild difficulty Moderate difficulty Severe Difficulty Barely able to function

1. General Mood (Depression, Anxiety, etc.) _____ 2. Social Relationships? _____ 3. Daily work or school?____

AXIS I: DSM-IV: Self-Report Checklist of Preliminary Items for Major Categories **Initials _____**

MD

In the last month has there been a period of time (of 2 weeks or more) when you were feeling depressed or down most of the day nearly every day? ..... No Yes
Have you felt a lot less interested in things or unable to enjoy the things you used to enjoy? (Was it most of the day nearly every day for at least two weeks?) ..... No Yes

DYS

For two years or more, have you been bothered by depressed mood most of the day, more days than not? ..... No Yes

Have you felt any of the following? Please check:

Pronounced weight loss or weight gain	_____	Difficulty concentrating/indecisive	_____
Sleeping too much or too little	_____	Recurrent thoughts of death, dying or hurting yourself	_____
Fidgety/Agitated or restless behavior	_____	Making a plan for suicide	_____
Feeling slowed down, sluggish	_____	Taking some action toward suicide ...	_____
Feelings of worthlessness or excessive guilt	_____	Fatigue or loss of energy	_____

PMD

Have you ever before had a 2 week period when you were feeling depressed or down more days than not? ..... No Yes

MN

In the last month, has there been a period of time when you were feeling so good, high, excited or hyper that other people thought you were not your normal self or you got into trouble? (Did anyone say you were manic? Was that more than just feeling good?) ..... No Yes
Has there been a period of time when you felt so irritable that you shouted at people or started fights/arguments? . No Yes

PMN

Have you **ever** had a time when you were feelings so good or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble: (Did anyone say you were manic, then?) ..... No Yes

DEL

Have you had any unusual experiences, for example did it ever seem like people were talking about youor taking special notice of you? ..... No Yes
What about receiving special messages from people or from the way things were arranged around you, or from the newspaper, radio, or TV? ..... No Yes

SCH

Other than when you were depressed or feeling high, has there been a time when you heard voices, had visions, or saw or smelled things that others couldn't see or smell? ..... No Yes
Or did you do something to call attention to yourself like dressing in some odd way or doing something strange? . No Yes

ALC

Was there ever a period in you life when you drank too much? (Has alcohol ever caused problems for you?) ..... No Yes
Has anyone ever objected to your drinking - or a doctor told you to stop drinking? ..... No Yes
Have you gone 'on the wagon' or ever tried to cut down on your drinking? ..... No Yes

DRG

Have you used any street drugs, or used prescription drugs in an amount or way that wasn't prescribed? ..... No Yes
If street drug: Has there ever been a time when you took it at least ten times in a one month period of time? ..... No Yes
If prescribed: Did you ever get hooked/dependent? ..... No Yes

Axis I: Continued **Initials _____**

PAN

Have you ever had a panic attack, when you felt frightened, anxious, uncomfortable, worried about going crazy or suddenly developed a lot of physical symptoms (e.g., heart-pounding, trembling, dizziness)? ..... No Yes
If yes, has the panic attack been followed by persistent concern about having additional attacks, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks? ..... No Yes

OC

Have you ever been bothered by thoughts**,** impulses or images that caused anxiety and kept coming back even when you tried not to have them? ..... No Yes
What about awful thoughts, like hurting someone against your will, or being contaminated by germs or dirt? ..... No Yes
Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting up to a certain number or checking something several times to make sure you'd done it right? ..... No Yes

PTSD

Is there a traumatic event or memory that keeps coming back in nightmares, flashbacks or thoughts—that you can't put out of your mind, & which continues to cause you great distress? ..... No Yes

AGR

Have you been afraid of leaving the house alone, being in crowds, standing in line, or traveling on buses or trains? ..... No Yes

Have you felt any of the following? Please check:

Pounding, racing heart . ___	Chest pain or discomfort .. ___	Fear of losing control, going crazy ___
Sweating ..... ___	Nausea/abdominal distress___	Fear of dying ..... ___
Trembling, shaking ..... ___	Dizzy, lightheaded or faint___	Numbness or tingling sensation ... ___
Shortness of breath ..... ___	Feelings of unreality or	Chills or hot flushes ..... ___
Feelings of choking ..... ___	detached from oneself .. ___	

SOC

Is there anything that you were ever afraid of or uncomfortable doing in front of other people like speaking, eating or writing? ..... No Yes

PHB

Are there any other things that you have been especially afraid of such as flying, snakes, seeing blood, getting a shot, heights, closed places or certain kinds of animals or insects? ..... No Yes

GAD

In the last six months, have you been particularly nervous or anxious? ..... No Yes
Do you worry a lot about terrible things that might happen? ..... No Yes

Have you felt any of the following? Please check:

Restlessness or feeling keyed up or on edge ..... _____	Irritability ..... _____
Being easily fatigued ..... _____	Muscle tension ..... _____
Difficulty concentrating or mind going blank ..... _____	Difficulty sleeping or restless sleep ... _____

SM/HY

Over the last several years, have you had to go to the doctor often because you weren't feeling well? ..... No Yes
Have you worried that something was wrong, even when a doctor told you there was nothing the matter? ..... No Yes

ANO

Have you ever had a time when you weighed much less than other people thought you ought to weigh? ..... No Yes
At that time were you very afraid that you could become fat? ..... No Yes

BUL

Have you often had times when your eating was out of control? ..... No Yes
Have you ever made yourself throw-up, used laxatives or exercised a lot to prevent weight gain? ..... No Yes

ADD

Have you had trouble concentrating on things or paying attention for at least 6 months? ..... No Yes
Have you had symptoms of hyperactivity, impulsivity, or restlessness that has persisted for at least 6 months? ..... No Yes

AXIS II: DSM-IV: Self-Report Checklist of Preliminary Items for Major Categories **Initials _____**

AVD

1.	Have you avoided jobs or tasks that involved having to deal with a lot of people?	No Yes
2.	Do you avoid getting involved with people unless you are certain they will like you?	No Yes
3.	Do you find it hard to be "open" even with people you are close to?	No Yes
4.	Do you often worry about being criticized or rejected in social situations?	No Yes
5.	Are you usually quiet when you meet new people?	No Yes
6.	Do you believe that you're not as good, as smart, or as attractive as most other people?	No Yes
7.	Are you afraid to try new things?	No Yes

DEP

8.	Do you need a lot of advice or reassurance from others before you can make everyday decisions?	No Yes
9.	Do you depend on other people to handle important areas in your life such as finances, child care or living arrangements?	No Yes
10.	Do you find it hard to disagree with people even when you think they are wrong?	No Yes
11.	Do you find it hard to start work on tasks when there is no one to help you?	No Yes
12.	Have you often volunteered to do things that are unpleasant?	No Yes
13.	Do you usually feel uncomfortable when you are by yourself?	No Yes
14.	When a close relationship ends, do you quickly need to find someone else you can rely on?	No Yes
15.	Do you worry a lot about being left alone to take care of yourself?	No Yes

OC

16.	Are you the kind of person who focuses on details, order, organization or likes to make lists and schedules?	No Yes
17.	Do you have trouble finishing jobs because you spend so much time trying to get things exactly right?	No Yes
18.	Do you (or others) feel that you are so devoted to work (school) that you have no time for others or for fun?	No Yes
19.	Do you have very high standards about what is right and what is wrong?	No Yes
20.	Do you have trouble throwing things out because they might come in handy someday?	No Yes
21.	Is it hard for you to let other people help you unless they agree to do things exactly the way you want?	No Yes
22.	Is it hard for you to spend money on yourself and other people even when you have enough?	No Yes
23.	Are you often so sure you are right that it doesn't matter what other people say?	No Yes
24.	Have other people told you that you are stubborn or rigid?	No Yes

NEG

25.	When someone asks you to do something that you don't want to do, do you then work slowly or do a bad job?	No Yes
26.	Often, if you don't want to do something, do you just 'forget" to do it?	No Yes
27.	Do you often feel that other people don't understand you, or don't appreciate how much you do?	No Yes
28.	Are you often grumpy and likely to get into arguments?	No Yes
29.	Have you found that most of your bosses, teachers, doctors, and others who are supposed to know what they are doing, really don't?	No Yes
30.	Do you often think that it's not fair that other people have more than you do?	No Yes
31.	Do you often complain that more than your share of bad things have happened to you?	No Yes
32.	Do you angrily refuse to do what others want and then later feel bad and apologize?	No Yes

DPR

33.	Do you usually feel unhappy or like life is no fun?	No Yes
34.	Do you believe that you are basically an inadequate person and often don't feel good about yourself?	No Yes
35.	Do you often put yourself down or blame yourself for things that haven't worked out?	No Yes
36.	Are you a worrier?	No Yes
37.	Do you often judge others harshly and easily find fault with them?	No Yes
38.	Do you think that most people are basically no good?	No Yes
39.	Do you almost always expect things to turn out badly?	No Yes
40.	Do you often feel guilty about things you have or haven't done?	No Yes

Axis II: Continued **Initials _____**

SDF

X1.	Have you repeatedly been involved with friends or lovers who have taken advantage of you or let you down?	No Yes
X2.	Have you sometimes gotten into bad situations where you wound up being taken advantage of?	No Yes
X3.	Do you often refuse help from other people because you don't want to bother them?	No Yes
X4.	When people try to help you, do you find it hard to accept or do you make it hard for them to help you?	No Yes
X5.	When you are successful, do you feel depressed or like you don't deserve it, or do something to spoil it?	No Yes
X6.	Do you often turn down the chance to do things that you really enjoy?	No Yes

PAR

41.	Do you often have to keep an eye out to stop people from using you or hurting you?	No Yes
42.	Do you spend a lot of time wondering if you can trust your friends or the people you work with?	No Yes
43.	Do you find that it is best not to confide in others because they will use it against you?	No Yes
44.	Do you often pick up hidden threats or insults in what people say or do?	No Yes
45.	Are you the kind of person who holds grudges or takes a long time to forgive when insulted or slighted?	No Yes
46.	Are there many people that you can't forgive because they did or said something to you a long time ago?	No Yes
47.	Do you often get angry or lash out when someone criticizes or insults you in some way?	No Yes
48.	Have you often suspected that your spouse or partner has been unfaithful?	No Yes

SZD

49.	When you are out in public and see people talking, do you often feel that they are talking about you?	No Yes
50.	Do you often feel that things that have no special meaning to most people are really meant to give you a message?	No Yes
51.	Do you often detect hidden messages in seemingly unrelated events?	No Yes
52.	Have you ever felt that you could make things happen just by making a wish or thinking about them?	No Yes
53.	Have you had personal experiences with the supernatural?	No Yes
54.	Do you believe that you have a 'sixth sense' that allows you to know or predict things that others can't?	No Yes
55.	Do you often think that objects or shadow are really people or animals or that noises are actually voices?	No Yes
56.	Have you had the sense that some person or force is around you, even though you cannot see anyone?	No Yes
57.	Do you often see auras or energy fields around people?	No Yes
58.	Are there very few people that you are really close to outside of your immediate family?	No Yes
59.	Do you often feel nervous when you are with other people?	No Yes

STP

60.	Is it NOT important to you whether you have any close relationships, including being part of a family?	No Yes
61.	Would you almost always rather do things alone than with other people?	No Yes
62.	Could you be content without ever being sexually involved with another person?	No Yes
63.	Are there really very few things that give you a lot of pleasure?	No Yes
64.	Does it not matter to you what people think of you?	No Yes
65.	Do you find that nothing makes you very happy or very sad?	No Yes

HIS

66.	Are you uncomfortable if you are not the center of attention?	No Yes
67.	Do you flirt a lot?	No Yes
68.	Do you often find yourself "coming on" to people?	No Yes
69.	Do you try to draw attention to yourself by the way you dress or look?	No Yes
70.	Do you often make a point of being dramatic and colorful?	No Yes
71.	Do you often change your mind about things (opinions) depending on the people you're with or what you have just read or seen on TV?	No Yes
72.	Do you have lots of friends that you are very close to?	No Yes

Axis II continued **Initials _____**

NAR

73.	Do most people fail to appreciate your very special talents or accomplishments?	No Yes
74.	Have people told you that you have too high an opinion of yourself?	No Yes
75.	Do you think a lot about the power, fame, or recognition that will be yours someday?	No Yes
76.	Do you think a lot about the perfect romance that will be yours someday?	No Yes
77.	When you have a problem, do you almost always insist on seeing the top person?	No Yes
78.	Do you feel it's important to spend time with people who are special or influential?	No Yes
79.	Is it very important to you that people pay attention to you or admire you in some way?	No Yes
80.	Do you think that it's not necessary to follow certain rules or social conventions when they get in your way?	No Yes
81.	Do you feel that you are the kind of person who deserves special treatment?	No Yes
82.	Do you often find it necessary to step on a few toes to get what you want?	No Yes
83.	Do you often have to put your needs above other people's?	No Yes
84.	Do you often expect other people to do what you ask without question because of who you are?	No Yes
85.	Are you NOT really interested in other people's problems or feelings?	No Yes
86.	Are you often envious of others?	No Yes
87.	Do you feel that others are often envious of you?	No Yes
88.	Do you find that very few people are worth your time and attention?	No Yes

BOR

89.	Have you often become frantic when you thought that someone you really care about was going to leave you?	No Yes
90.	Do your relationships with people you really care about have a lot of extreme ups and downs?	No Yes
91.	Have you abruptly changed your sense of who you are and where you are headed?	No Yes
92.	Does your sense of who you are often change dramatically?	No Yes
93.	Have there been lots of sudden changes in your goals, career plans, religious beliefs, and so on?	No Yes
94.	Have you often done things impulsively (e.g., spending, sex, reckless driving)?	No Yes
95.	Have you tried to hurt or kill yourself or threatened to do so?	No Yes
96.	Have you ever cut, burned or scratched yourself on purpose?	No Yes
97.	Are you a 'moody' person?	No Yes
98.	Do you often feel empty inside?	No Yes
99.	Do you often have temper outbursts or get so angry that you lose control?	No Yes
100.	Do you hit people or throw things when you get angry?	No Yes
101.	Do even little things get you very angry?	No Yes
102.	When you are under a lot of stress, do you get suspicious of other people or feel especially spaced out?	No Yes

ANT

BEFORE THE AGE OF 15 DID YOU EVER DO ANY OF THE FOLLOWING:		
103.	Did you bully or threaten other kids?	No Yes
104.	Did you start fights?	No Yes
105.	Did you hurt or threaten someone with a bat, brick, broken bottle, knife or a gun?	No Yes
106.	Did you ever deliberately try to cause someone physical pain and suffering?	No Yes
107.	Did you torture or hurt animals on purpose?	No Yes
108.	Did you ever rob, mug or forcibly take something from someone by threatening him or her?	No Yes
109.	Did you ever force someone to have sex with you?	No Yes
110.	Did you set fires?	No Yes
111.	Did you deliberately destroy things that weren't yours?	No Yes
112.	Did you ever break into a house, other buildings, or cars?	No Yes
113.	Did you lie a lot or "con" other people?	No Yes
114.	Did you sometimes steal, shoplift things or forge someone's signature?	No Yes
115.	Did you run away from home and stay away overnight?	No Yes
116.	Would you often stay out very late, long after the time you were supposed to be home?	No Yes
117.	Did you often skip school?	No Yes

Larissa Humiston, LCSW
Office Policies & Procedures

Appointments/ Office Hours

- Office hours are Monday thru Friday 7am-7pm.
- Appointments will be scheduled in 50-minute increments during the above times. Please be advised that weekend appointments are not available.
- Walk-in appointments are not available.

Cancellation

- Because your appointment time is set aside specifically for you, please notify me by telephone (407-415-1175) at least 24 hours in advance if you need to cancel or reschedule an appointment. Without such notice I will charge your regular session fee for the missed appointment. I do not accept text or e-mail cancellations at this time. Appointments scheduled for Mondays will need to be cancelled no later than 5pm on the Friday before or will be subject to full fee.
- I will wait 15 minutes into a scheduled session before it is considered a "no show". Full charge will be due.

Fees/ Insurance

- Fees are $120 per 50-minute session for individual sessions. My rate is $200 per session for all couples and families. All fees are due at the beginning of your session and can be paid in cash or Venmo. Major credit cards are able to be accepted for an additional $5 per transaction fee. Checks are not accepted.
- I do take some insurances. You will be responsible for your copay, and if for any reason your insurance does not cover the sessions, you will be responsible for the full rate.
- At this time I am in-network for a limited number of insurance companies. If I am in-network for your insurance company, I will submit the paperwork for reimbursement for your treatment. I will collect any co-pays that you have at each session. If for any reason your insurance company does not pay, you are responsible for full payment. If I am out-of-network for your Insurance Plans, I will provide a receipt that you may submit to your insurance company for reimbursement, or you may want to inquire about "out of network" benefits, which some insurance companies provide. If you are covered for mental health services with out-of-network benefits you will be responsible to pay your fees in full and submit your paid bill to your insurance provider for reimbursement to you.
- I do not offer a sliding scale fee.
- If you are using your insurance EAP, I am happy to see you for two cycles of sessions. After that, you will either need to be referred out, or pay my full rate or your insurance rate if I accept your insurance. If you choose to continue getting EAP sessions, you will need to pay the difference in cost (ie, Aetna EAP pays $60 to the therapist for the session, if the full fee is $120, you will be responsible for $60).

Telephone/ Email

- Telephone calls are returned during normal business hours. I do not answer the phone if I am with another client, colleague, or if I am in a meeting or conference. I check my voicemail frequently and

am usually able to answer phone calls within in 24 hours if during normal business hours. I generally do not return phone calls after 8pm on business days or on weekends. I do not provide emergency services, if you are in need of emergency services, please dial 911 or go to your nearest Emergency Room. If I am unavailable for any extended period of time, I will provide the name and number of another clinician whom you may contact if need be.

- Please keep in mind that email does not always protect your confidentiality. I do not accept cancellations or changes to your appointment via email or text, only phone calls.

Record Keeping/ Legal Proceedings

- I am required both by law and by the standards of my profession to keep appropriate treatment records. These include diagnosis, therapy goals, progress in treatment, documentation of mandated disclosures (child abuse etc.) and any other information. You have the right to review and/or receive a copy of your records at any time unless I feel that by doing so, may cause substantial emotional harm, endanger your life in any way, or pose a significant risk or harm to another individual. Alternatively, I can prepare a treatment summary of these records. Due to language used in these records, if you would like to review your records or treatment summary, I suggest you do so in my presence, so that I can clarify or answer any questions you may have. Records can only be released to another individual, therapist, doctor etc. with your written permission. If you were involved in couple of family therapy, all adults involved would also have to sign the release.
- If you ever become involved in a custody or other legal dispute, I do not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because we have had a therapy relationship, and (2) The testimony might affect our therapy relationship, and I must put this relationship first. For any legal preparation my fee is $250/hour.

Miscellaneous

- All files are confidential and are kept in a locked file cabinet. Even after the end of your treatment, files will be kept for at least 7 years as stated by Florida Department of Health Statutes.
- Any electronic files will be password protected to keep confidentiality.

I have read and understand the above policies and agree to them as stated above.

Client Name (Print): _____ Client Signature: _____

Date: _____ Therapist Reviewed: _____

Larissa Humiston, LCSW
1414 Gay Rd Suite 205 Winter Park, FL 32789
122 N. 4th Street Suite 2006 Lake Mary, FL 32746
NOTICE OF PRIVACY PRACTICES

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.

I am required by law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I will follow the privacy practices that are described in this Notice. If I amend this Notice, I will provide you with the amended Notice for your information and signature.

For more information about my privacy practices, or for additional copies of this Notice, please let me know your questions as soon as they arise.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. **Permissible Uses and Disclosures Without My Written Authorization.** I may use and disclose your PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures of your mental health information that are legally permissible.

1. **Treatment:** I may use and disclose your PHI to other clinicians involved in your care in order to better provide integrated treatment to you. For example, I may discuss your diagnosis and treatment plan with your psychiatrist or nurse practitioner. In addition, I may disclose your PHI to other health care providers in order to provide you with appropriate care and continued treatment.

2. **Payment:** I may use or disclose your PHI for the purposes of determining coverage, billing, claims management, and reimbursement. For example, a bill sent to your health insurer may include some information about our work together so that the insurer will pay for the treatment. I may also inform your health plan about a treatment you are going to receive in order to determine whether the plan will cover the treatment.

3. **Health Care Operations:** I may use and disclose your PHI in connection with health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For, example, I may disclose disguised information about our work for training purposes.

4. **Required or Permitted by Law:** I may use or disclose your PHI when I am required or permitted to do so by law. For example, I may disclose your PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. In addition I may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other

disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access your PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; disclosures for workers' compensation claims, and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions as authorized by law.

B. Permissible Uses and Disclosures That May Be Made Without My Authorization, But For Which You Have An Opportunity to Object.

1. **Fundraising:** I may use your PHI to contact you in an effort to offer you new services. I may also disclose PHI to any foundation with which I am connected so that the foundation may contact you in an effort to raise money for its operations. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications.

2. **Family and Other Persons Involved in Your Care.** I may use or disclose your PHI to notify, or assist in the notification of (including identifying or locating) your personal representative, or another person responsible for your care, location, general condition, or death. If you are present, then I will provide you with an opportunity to object prior to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose your PHI consistent with your prior expressed preference, and in your best interest as determined by my professional judgment. I will also use my professional judgment and my experience to make reasonable inferences of your best interest in allowing another person access to your PHI regarding your treatment with me.

3. **Disaster Relief Efforts.** I may use or disclose your PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

C. **Uses and Disclosures Requiring Your Written Authorization.**

1. **Psychotherapy Notes.** I will not disclose the records of our work that I keep separate from the medical record for my personal use, known as psychotherapy notes, except as permitted by law.

2. **Marketing Communications; Sale of PHI.** I must obtain your written authorization prior to using or disclosing your PHI for marketing or the sale of your PHI, consistent with the related definitions and exceptions set forth in HIPAA.

3. **Other Uses and Disclosures.** Uses and disclosures other than those described in this Notice will only be made with your written authorization. For example, you will need to sign an authorization form before I can send your PHI to your life insurance company or to your attorney. You may revoke any such authorization at any time by providing me with written notification of such revocation.

II. MY INDIVIDUAL RIGHTS

A. **Right to Inspect and Copy.** You may request access to your medical records and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested.

B. **Right to Alternative Communications.** You may request, and I will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

C. **Right to Request Restrictions.** You have the right to request a restriction on your PHI that I use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to **Larissa Humiston, LCSW- 1414 Gay Rd. Suite 205, Winter Park, FL 32789**. I am not required to agree to any such restriction you may request, except if your request is to restrict disclosing your PHI to a health plan for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf.

D. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of disclosures of your PHI made by me in the last six years, subject to certain restrictions and limitations.

E. **Right to Request Amendment:** You have the right to request that I amend your PHI. Your request must be in writing, and should explain why the information should be amended. I may deny your request under certain circumstances.

F. **Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to **Larissa Humiston, LCSW- 1414 Gay Rd Suite 205 Winter Park, FL 32789** at any time.

G. **Right to Receive Notification of a Breach.** I am required to notify you if I discover a breach of your unsecured PHI, according to requirements under federal law.

H. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, please contact me at **407-415-1175.** You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on _____.

B. Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office and on my website at LarissaHumiston.com You may also obtain any revised notice by asking me directly.

Larissa Humiston, LCSW
1414 Gay Rd Suite 205 Winter Park, FL 32789
122 N. 4th Street Suite 2006 Lake Mary, FL 32746
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of her Notice of Privacy Practices.

_____
Printed name of client

_____ _____
Signature of client Date

_____ _____
Signature of LCSW Date

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

Personal Representative' Name: _____

Relationship to Client: _____

For Office Use Only

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

1. Individual refused to sign
2. Communications barriers prohibited obtaining the acknowledgement
3. An emergency situation prevented us from obtaining acknowledgement
4. Other (Please Specify)

This form will be retained in your medical record
by Larissa Humiston, LCSW