Intake Packet

Demographics

Demographics

Client Name

[redacted]
First

[redacted]
Last

Preferred Name (optional)

[redacted]
Preferred Name

Please input the client's legal name: [redacted]

Date of Birth

[redacted]

Address

[redacted]
Address Line 1

Colorado Springs
City

Colorado
State

80918
Zip Code

Cell Phone

[redacted]

Home Phone

Work Phone

[redacted]

Client's Email

[redacted]

Gender

○ Male ◉ Female

Marital Status

Married
Martial Status

Race

White
Race

Ethnicity

Non Hispanic or Latino
Ethnicity

Emergency Contact

Emergency Contact Name

[redacted]
First

[redacted]
Last

Emergency Contact Phone

[redacted]

Emergency Contact Relationship

Spouse
Relationship

History

History

Client: [redacted] | **DOB**: 04/21/1992

Please describe the primary reason you are seeking treatment.

Anxiety that is worsened by my ADHD

What is the impact on your quality of life? How do problems/symptoms keep you from doing your job or daily life?

I feel overwhelmed and like I cannot function. I have reduced my hours at work

Problem/Symptom checklist

- ☐ abuse/trauma
- ☐ aging/dependency
- ☐ alcohol/drugs
- ☐ anger control
- ☐ being single
- ☐ child custody
- ☐ children
- ☐ church/ministry
- ☐ codependency
- ☐ communication
- ☑ depression
- ☐ disabled
- ☐ divorce/separation
- ☐ family
- ☑ fear/anxiety
- ☐ God/faith
- ☑ grief/loss
- ☐ hallucinations (auditory/visual)
- ☐ homicidal thoughts
- ☐ in-laws
- ☐ intimacy
- ☑ loneliness
- ☐ marriage
- ☐ money/budgeting
- ☐ mood swings
- ☐ other addictions
- ☐ parents
- ☐ past hurts
- ☐ physical abuse (perpetrator)
- ☐ physical abuse (victim)
- ☐ pre-marital
- ☐ school/learning
- ☑ self-esteem
- ☐ self-injury
- ☐ sexual abuse (perpetrator)
- ☑ sexual abuse (victim)
- ☐ sexual issues
- ☑ stress control
- ☐ weight control
- ☐ work/career

Have you experienced any thoughts or desires of ending your life, or causing harm to yourself within the past 90 days?

○ Yes, within the last 90 days ○ Yes, prior to 90 days ago ⊙ No

What significant life changes or stressful events have you experienced recently?

My husband works evenings and I have too much time to think and focus on negative things. I miss my family back home, and my dogs I have had for 13 & 15 years are getting older and it's harder than I thought it would be.

What would you like to accomplish out of your time in therapy?

I would like to learn ways to talk myself through my emotions and not always think everything is negative

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

Previous therapist/practitioner

Cara Domer (Psychiatrist)

⊙ Yes ○ No

What do you consider to be some of your strengths?

Very authentic, loving, devoted

Family Psychiatric History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Family Member 1

Family Member's Relationship to you

Mother

i.e. Father, Mother, Grandfather...

Mental Health History of Mother

- ☐ Alcohol/ Substance Abuse
- ☐ Domestic Violence
- ☑ Depression
- ☐ Obsessive Compulsive Behavior
- ☑ Anxiety
- ☑ Obesity
- ☐ Suicide Attempts
- ☐ Schizophrenia
- ☑ Eating Disorder

Family Member 2

Family Member's Relationship to you

Father

i.e. Father, Mother, Grandfather...

Mental Health History of Father

- ☐ Alcohol/ Substance Abuse
- ☐ Domestic Violence
- ☑ Depression
- ☐ Obsessive Compulsive Behavior
- ☑ Anxiety
- ☐ Obesity
- ☐ Suicide Attempts
- ☐ Schizophrenia
- ☐ Eating Disorder

Family Member 3

Family Member's Relationship to you

Stepmother

i.e. Father, Mother, Grandfather...

Mental Health History of Stepmother

- ☐ Alcohol/ Substance Abuse
- ☐ Domestic Violence
- ☑ Depression
- ☐ Obsessive Compulsive Behavior
- ☑ Anxiety
- ☑ Obesity
- ☐ Suicide Attempts
- ☐ Schizophrenia
- ☑ Eating Disorder

Medical Conditions & History

Are you currently taking any prescription medication (psychiatric or others)?

⊙ Yes ○ No

Prescriptions

Prescription 1

Medication Name	Purpose	Prescriber
Vyvanse	AdHD	Cara Domer

Prescription 2

Medication Name	Purpose	Prescriber
Birth control pill	Birth control	NP Kezia

Last Physical Exam
4/3/2023

Dental History
Every 6-8 months

Allergies?
○ Yes ⊙ No

Do you have Advanced Directives?
○ Yes ⊙ No

Substance Use History

Do you drink alcohol?
⊙ Yes ○ No

Please explain the onset, frequency, and amount of alcohol you use.
Primarily 5-6 over the course of the weekend

Do you engage in recreational drug use?
○ Yes ⊙ No

Family & Social History

Please describe your current living arrangement (Do you live with others?)
I live with my husband and 2 dogs

Do you have any social supports (i.e., church, friends, support groups)?
○ Yes ⊙ No

Family Relationship

	Very Poor	Poor	Average	Good	Very Good	N/A
How would you describe your relationship with your Father?	○	○	○	○	⊙	○
How would you describe your relationship with your Mother?	○	○	○	⊙	○	○
How would you describe your relationship with your Siblings?	○	○	⊙	○	○	○

Spiritual/Cultural Factors

Do you consider yourself to be spiritual or religious?
○ Yes ⊙ No

Developmental History

Do you have any developmental delays or milestones?
○ Yes ⊙ No

Educational/Vocational History

Are you currently employed?
⊙ Yes ○ No

What is your occupation?
Hairstylist

Are you in school?
○ Yes ⊙ No

Legal History

Do you have any legal history (arrests, prison, DWI)?
○ Yes ⊙ No

Parent/Guardian

Parental Information

Client: [redacted] | **DOB**: 04/21/1992

Select the appropriate age range of the client, [redacted]

○ 11 years and under ○ 12 to 14 years old ○ 15 to 17 years old ⊙ 18+ years old

18+ years old

Parental information is not required. Please continue to the next form.

Attendees

Attendees

Client: [redacted] | **DOB**: 04/21/1992

Select the service you are seeking:
⊙ INDIVIDUAL Therapy/Psychiatry ○ COUPLES / FAMILY Therapy

Individual Therapy/Psychiatry

No attendee information is required. Please continue to the next form.

Insurance/Payment

Insurance/Payment Acknowledgement

Client: [redacted] | **DOB**: 04/21/1992

Select your service:
⊙ Individual Therapy or Psychiatry ○ Couples or Family Therapy

Individual Therapy or Psychiatry

What is your primary insurance carrier?

I have Medicaid

Health First Colorado Client Rights and Responsibilities

Medicaid ID #

[redacted]

i.e. P123456

i.e. P123456

Kindly be aware that your Medicaid coverage undergoes evaluation on a monthly basis. Should your coverage with Medicaid cease before your scheduled session, you will be held accountable for any applicable session fees.

I understand that Medicaid is a 'last-resort' payer, meaning IF I have other insurance (i.e. Anthem, Aetna, etc.) they must be billed first. If not, Medicaid will deny the claims and I'll be responsible for the session fees.
⊙ Yes ○ No

As a member of Health First Colorado, you have rights and responsibilities.

Your Rights

You have the right to:

1. Get the information in this handbook and about your coverage, plans, benefits and services.
2. Be treated with respect and consideration for your privacy and dignity.
3. Get information in a way you can easily understand.
4. Get information from your provider about treatment choices for your health condition.
5. Be involved in all decisions about your health care and say “no” to any treatment offered.
6. Not be secluded or restrained as a punishment or to make things easier for your provider.
7. Ask for and get a copy of your medical records and ask that they be changed or corrected.
8. Get quality health care services in a timely and coordinated way.
9. Use your rights without fear of being treated poorly.
10. Any other rights guaranteed by law.
11. Be free from discrimination based on race, color, ethnic or national origin, ancestry, age, sex,

gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, disability or health status.

12. Ask your health plan for help if your provider does not offer a service you need because of moral or religious reasons.

Your Responsibilities

You have the responsibility to:

1. Understand your rights.
2. Follow this Health First Colorado's (Colorado's Medicaid Program) handbook.
3. Treat other members, your providers and staff with respect.
4. Choose a primary care provider and go to HealthFirstColorado.com. Or call 303-839-2120 or 888-367-6557 (State Relay 711) if you want to see a different provider.
5. Pay for services you get that are not covered by Health First Colorado.
6. Tell your provider and Health First Colorado if you have any changes to your family, income, jobs, other insurance or address.
7. Ask questions when you do not understand or want to learn more.
8. Tell your provider information they need to care for you, such as your symptoms.
9. Take medications as prescribed and tell your provider about side effects or if your medications are not helping.
10. Invite people who will be helpful and supportive to you to be included in your treatment.
11. Report suspected member or provider fraud or abuse to Member Fraud at 844-475-0444 or Provider Fraud at 855-375-2500. Or go to CO.gov/HCPF/how-reportsuspected-fraud.

Medicaid Member's Notice

Transportation

Most Health First Colorado members can get a ride using IntelliRide. **If you live in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer, or Weld County:**

Call IntelliRide at 1-855-489-4999 (toll free) (State Relay 711) or go to Gointelliride.com/Colorado to get a ride, including air, train, or out-of-state travel. Or, request mileage reimbursement if you use a personal vehicle.

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If you live in any other Colorado county:

Contact a local NEMT provider in your community. Go to hcpf.colorado.gov/nemtlist to find a local NEMT provider.

If you need personal vehicle mileage reimbursement, air, train or out-of-state travel, call IntelliRide at 1-855-489-4999 (toll free) (State Relay 711) or go to Gointelliride.com/Colorado.

Finding A PCP

Medicaid Members, please visit https://www.healthfirstcolorado.com/find-doctors/ to find a PCP. Also, visit EPSDT (Early and Periodic Screening, Diagnostic and Treatment) for additional information about preventive services.

Advanced Directives

Medicaid Members, please visit the Member Handbook to learn more about Advanced Directives.

☑ I have read and understood my Medicaid Client Rights and Responsibilities.

☑ I understand my transportation options.

☑ I've been notified of my PCP options.

☑ I been notified of my advanced directive options.

Signature

Today's Date

7/3/2024

Printed Name

[redacted]

First

[redacted]

Last

Late Cancellation and No-show Policy

We have a late cancellation and no-show policy.

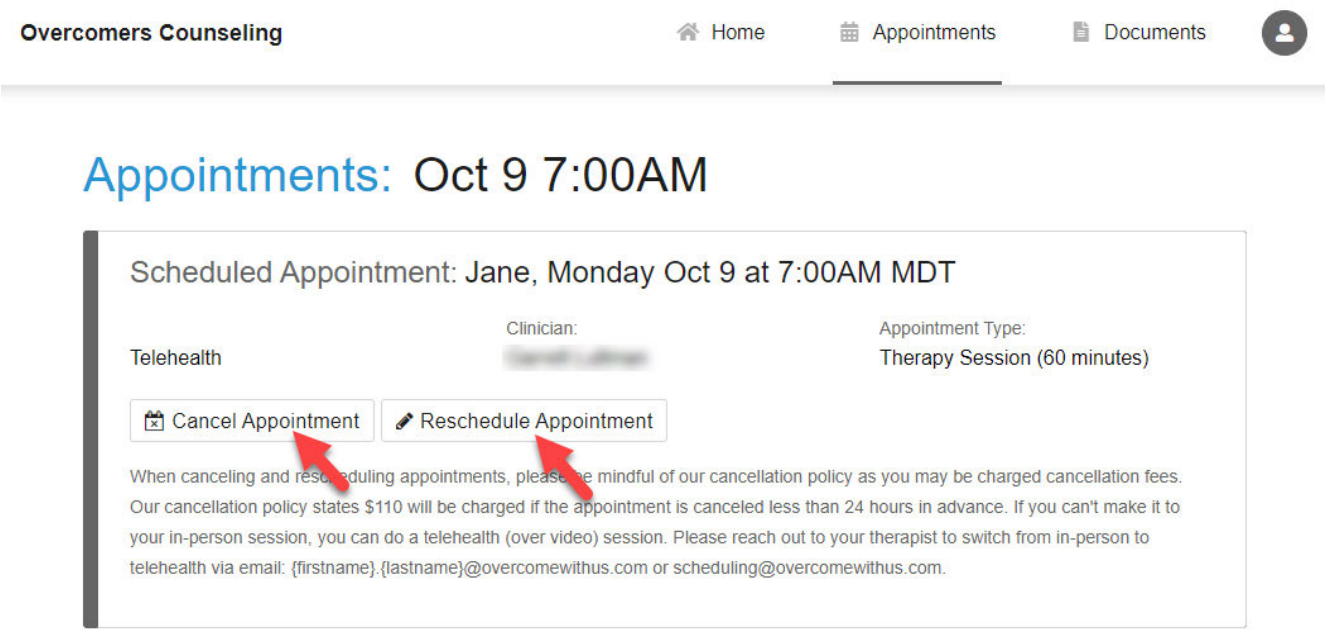
This policy is important because, while a medical doctor can see 35 patients in a day, a therapist generally sees 6. We reserve for you a full hour of our time for the session and clinical notes. If a client cancels with less than 24-hours notice, we lose an entire hour from our schedule. The 24-hours notice gives us at least a shot at filling that hour.

You can cancel or reschedule an appointment anytime, as long as you give 24-hours notice. If

you cancel an appointment with less notice or don't show up, you will be charged a standard **$110 fee**.

We're never upset with clients when they miss an appointment. We know that's life. In return, our clients understand that the cancellation fee is not a penalty or punishment, but a necessary policy so that we can continue to provide our clients the care they deserve. It's important to know that insurance will not pay for missed appointments, so you will be responsible for the full $110, not just a co-pay.

You may easily cancel or reschedule your sessions at any time in the Client Portal.



☑ I understand and agree to the Late Cancellation and No-Show Policy.

Disclosure (Therapy)

Disclosure Statement (Therapy)

Client: [redacted] | **DOB**: 04/21/1992

Please review the information. If you have any questions, contact your therapist. Please review the "About Me" document of your therapist for specific contact information, license, and education.

The Therapy Process

Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your Provider have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review your Provider's policies and procedures, talk about fees, identify emergency contacts, and decide if you want health insurance to pay your fees depending on your plan's benefits. Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment, and the risks and benefits. If your Provider is practicing under the supervision of another professional, your Provider will tell you about their supervision and the name of the supervising professional. Third, you will form a treatment plan, including the type of therapy, how often you will attend therapy, your short- and long-term goals, and the steps you will take to achieve them. Over time, you and your Provider may edit your treatment plan to be sure it describes your goals and steps you need to take. After intake, you will attend regular therapy sessions at your Provider's office or through video, called telehealth. Participation in therapy is voluntary - you can stop at any time. At some point, you will achieve your goals. At this time, you will review your progress, identify supports that will help you maintain your progress, and discuss how to return to therapy if you need it in the future.

Colorado Regulatory Responsibilities

Everyone twelve (12) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must sign this disclosure statement on behalf of their minor child under the age of twelve (12) years old. In accordance with best practices, the Mental Health professional will encourage the participation of client’s parents for youth under the age of 15. Additionally, the mental health professional may notify the parent or legal guardian, without the minor’s consent, if in their professional opinion the minor is unable to manage their own care or treatment, or if the minor expresses any suicidal ideation.

In divorce or custody situations and because of the Colorado Department of Regulatory Agencies view on parental consent, it is the Provider's policy to seek the consent of both parents/legal guardians, however, this consent does not supersede any court order outlining parental decision-making and custodial rights. This policy is irrespective of any court determination and this is the governing policy unless the child’s health, safety, and welfare could be at risk. If this is the case, you must inform the Provider so that appropriate action for the protection and welfare of the child may be taken. This disclosure statement contains the policies and procedures of the Provider and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and

Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your therapist.

Clinician Types And Education

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Colorado Department of Regulatory Agencies (DORA) can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. There are several types of clinicians who provide mental health services. Below is a list of clinician types along with the education and training required:

- An Unlicensed Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

- A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience.

- A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.

- A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.

- A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.

- A Licensed Social Worker must hold a master's degree from the graduate school of social work and pass an examination in social work.

- A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination in social work.

- A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.

- A Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one-year post-doctoral practice, and pass an exam in marriage and family therapy.

- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one-year postdoctoral practice, and pass an exam in professional counseling.

- A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.

Certified Addiction Technicians must be a high school graduate, complete required training hours, pass the National Addiction Exam, Level I or equivalent, and complete 1,000 hours of supervised experience. Certified Addiction Specialists must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselors must have a clinical master's degree, pass the Master Addiction Counselor Exam, and complete 3,000 of supervised experience. Licensed Social Workers must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in his or her profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. An Unlicensed Psychotherapist is a psychotherapist listed in Colorado's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state. Unlicensed Psychotherapists are required to take the jurisprudence exam. With the exception of Unlicensed Psychotherapists, all mental health professionals are required to complete continuing education for the duration of their active licenses.

Important Information

As a client, you have the right to receive information about the methods of therapy, the techniques used, the duration of therapy, and the fee structure. Please ask me directly if you'd like details regarding any of these areas. Also, you have the right to seek a second opinion from another therapist or may terminate therapy at any time.

In a professional counseling relationship, sexual intimacy is never appropriate and should be reported to the board that licensed, registers, or certifies the licensee, registrant, or certificate holder: The Colorado Department of Regulatory Agencies (DORA) can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

The information provided by the client during therapy sessions is legally confidential in the case of licensed marriage and family therapists, social workers, professional counselors, and psychologists; licensed or certified addiction counselors; and unlicensed psychotherapists. There are times when professionals would prefer to maintain confidentiality but cannot do so legally or ethically. Examples include instances when clients indicate an intention to harm themselves or someone else and when they have been abused or they know someone who is or has been abused.

Court And Litigation

Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $300.00 per hour.

About Our Services

It's our goal to offer a positive, empowering, and life-enriching experience for our clients. The potential benefits of counseling are many and include improved functioning, relationships, self-image, mood, and the attainment of personal goals. However, in some cases, people have reported feeling worse after counseling. Clients understand that healing and growth are difficult, and some discomfort will likely be a part of the counseling process.

Restrictions Of Uses

You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however, Company is not required to agree to a restriction request. Please review the Company's Notice of Privacy Policies for more information.

Second Opinion And Termination

You are entitled to seek a second opinion from another therapist or terminate therapy at any time.

Confidentiality

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the psychotherapist is a Licensed Psychologist, Licensed Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Certified and Licensed Addiction Counselor, or an Unlicensed Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-245-220. You should be aware that provisions concerning disclosure of confidential communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S. § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identified by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third

party may not access our communications. Even though I may utilize state-of-the-art encryption methods, firewalls, and backup systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third party. Please review and fill out Company's Consent for Communication of Protected Health Information by Unsecure Transmissions.

Extreme Risk Protection Orders Policy

According to C.R.S. § 13-14.5-103 a licensed health care professional or mental health professional (as defined in C.R.S. § 13-14.5-102) may file a petition for a temporary extreme risk protection order. Pursuant to article 14.5, an extreme risk protection order may warrant the surrender of firearm(s) when there is a significant risk of causing personal injury to self or others by having custody or control of a firearm(s). If at any time during the course of treatment the need to enact this policy arises, as the mental health professional, I shall make reasonable efforts to limit protected health information to the minimum necessary to accomplish the filing of the petition. The decision of a licensed health care professional or mental health professional to disclose protected health information, when made reasonably and in good faith to comply with this article, shall not be the basis for any civil, administrative, or criminal liability with respect to the licensed health care professional or licensed mental health professional.

"No Secrets" Policy

When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (i.e. on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless I am required to do so by law. However, in the event that you disclose information that is directly related to the treatment of the couple or family it may be necessary to share that information with the other members of the couple or the family in order to facilitate the therapeutic process. As your therapist, I will use my sole discretion and best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, I will first give the individual the opportunity to make the disclosure to the other party themselves. This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the couple or the family being treated. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist who can treat you individually.

"No Secrets" In Custody Circumstances Policy

When treating a Client who is a Minor under the age of twelve (12) and where there exists a custody arrangement between the parents or legal guardians (such as a divorce or separation), it is my policy to communicate with both parents/guardians via email (i.e. all communication will "cc" both parties). This policy is necessary to maintain transparency and professionalism, and to ensure the well-being of the therapeutic relationship with the Minor Client. This policy does not supersede any court order outlining decision-making or custodial rights but is or may be required by DORA. Further, I reserve the right, in my sole discretion, to engage in any individual email communication or face-to-face interaction in the lobby/waiting area. In the event that such an interaction occurs, I will notify the other party of said interaction and summarize the contents of the conversation, unless prohibited by professional rules or

regulations regarding the protection of the health, safety, and welfare of the child/ren.

Welfare Checks

When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.

Availability And Response Policy

The provider's normal business hours vary from day to day. However, as a provider, the majority of my business hours are devoted to seeing my clients in therapy, which means I am not always available for immediate contact via phone, text, or email. This is especially true for emergencies, as I am not equipped to respond immediately.

The best way to contact me is via (phone/email). Every effort will be made to respond to you in a clear and timely manner. Voicemails sent to my extension will be returned within 24 hours, excluding Saturdays, Sundays, and holidays. Emails sent to EMAIL will be returned within 24 hours, excluding Saturdays, Sundays, and holidays. It is my policy to return all phone calls, texts, and emails during my normal business hours. I also reserve the right, in my sole discretion, to return communication outside of these hours; but any communication which I initiate outside of these normal business hours is in no way a guarantee or a promise of availability outside of my normal business hours.

Minors

Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children who are under the age of 12, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

Electronic Communication & Online Counseling

Telephone, email, and video conference are not encrypted methods of communication, and some confidentiality risk exists with their use. Our team communicates using these mediums. Occasionally, your counselor, or someone from our team, may follow up with you by telephone or email for scheduling, billing, quality assurance, or other issues. If you would prefer not to be contacted by email, simply inform your counselor and your preferences will be respected. If you and your counselor are participating in distance counseling sessions the counselor will abide by the laws and ethical codes of his/her state of licensure. While a growing base of research has shown that distance counseling services—through various electronic means—can be effective, such services are relatively new in comparison to traditional (in-person) counseling, which has a much longer track record of positive outcomes. Distance counseling may not be appropriate for some clients and for the treatment of some mental health issues.

Recording

I agree not to record our session without your written consent, and you agree not to record a session or a conversation with me without my written consent.

Client Record Retention Policy

My records regarding the treatment of adults will be kept for seven (7) years after treatment ends or following our last session, but I may not retain them after seven years. My records for treatment of minors will be kept for seven (7) years, commencing on the last date of treatment or for seven years from the date when the minor reaches 18 years of age, whichever comes later. In no event am I required to keep these records for longer than 12 years.

Scheduling And Cancelations

Appointments can be canceled/rescheduled as long as a 24-hour notice is provided. If less than the required notice is given, the client agrees to pay a fee of $110 (insurance will not pay for missed appointments) and the client will lose their reserved time slot. Please note that we do enforce this policy. Medicaid has a policy that does not allow late cancellation fees. In this case, we provide a minimum of 3 no-charge, late cancellations. After the 3rd missed appointment, I will not be able to schedule another appointment with you for 3 months.

I will wait for 15 minutes after the scheduled start time and then the session will be terminated if no contact has been made within that time frame.

Social Media Policy

I understand that my therapist does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friends/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that Company has, or may have, a business social media account page. I understand that there is no requirement that I “like” or “follow” this page. I understand that should I “like” or choose to “follow” Company’s business social media page that others will see my name associated with “liking” or “following” that page. I understand that this applies to any comments that I post on Company’s page as well. I understand that any comments I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and not through social media.

Conflicts

We work hard to ensure that you have a positive experience. However, if a conflict occurs, it is agreed that any disputes shall be negotiated directly between the parties. If these negotiations are not satisfactory, then the parties agree to mediate any differences. Litigation shall be considered only if these methods are given a good faith effort.

Service Fees

Payment, including insurance co-pay, is due at the time of the service. The Client gives the practice permission to charge their credit/debit card on file for any outstanding dues. To change the payment method simply email billing@overcomewithus.com. Clients understand they are fully responsible for all fees if insurance or other vendors do not pay for any reason.

Payment of services is due at the time of your session. If for any reason you are unable to pay for your session fee and a balance has not been paid for two sessions you will be removed from my calendar and will not be scheduled for a future session until either the balance has been paid or a payment plan has been arranged. Once the balance has been paid or a payment plan has been arranged I will contact you and schedule a future session with you. This policy is designed to keep your best interest in mind and not to place you in a position of financial strain.

I understand that there will be times that we will need to communicate outside of a traditional session. When this is necessary, these phone calls/communications will be no longer than 10 minutes. If the communication lasts longer than 10 minutes a $40 self-pay fee will be charged for communication exceeding 10 minutes, and lasting no more than 22 minutes. A $60 self-pay fee will be charged for communication lasting 22-50 minutes or your copay rate. Any communication lasting over 50 minutes will be charged a full session self-pay fee of $100 or your copay rate and insurance will be billed for a full session.

The Client agrees to an additional charge (not billed through insurance) for any written letters. The charge will be billed at an hourly rate of $100 with a minimum of $30.

As a client at Overcomers Counseling, you have the right to receive a “Good Faith Estimate” in writing explaining how much your psychotherapy services will cost. Under federal law, health care providers, including mental health providers, are required to give patients who do not have insurance or who are not using insurance an estimate of the bill for medical items and services. You may request a Good Faith Estimate in advance of an already scheduled psychotherapy session or at any point during your treatment.

Insurance

I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my therapist, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my therapist’s entire client file. I understand that once my insurance company receives the information, neither I nor my therapist have any control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report the Provider submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.

Medicaid

Health First Colorado Member Billing Providers agree to accept the Health First Colorado payment as

payment in full for benefits. Colorado law (C. R. S. 25.5-4-301 (II)) provides that no Health First Colorado member shall be liable for the cost, or the cost remaining after payment by Health First Colorado, Medicare or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error, and whether or not the provider is enrolled in the Health First Colorado. This law applies even if a Health First Colorado member agrees to pay for part or all of a covered service. This law also prohibits providers from billing Health First Colorado members for the estates of deceased Health First Colorado members for Health First Colorado benefits. As such, Health First Colorado members are not responsible for payment for late cancellations or failure to show for an appointment.

As a client at Overcomers Counseling, it is your duty to disclosure, regardless of your age, whether you are a Medicaid beneficiary and therefore subject to Medicaid policies and procedures. If you have Medicaid as secondary coverage to your primary insurance carrier, I will be able to offer mental health services to you.

Services Provides & Referrals

Services included will be an assessment, counseling, and referrals to community services as needed. If, following the intake assessment the presenting issues require services beyond my scope as a provider, I will provide you with referrals through your insurance carrier or to a provider in the community that can provide more specialized therapy. We will discuss this together with you. We are legally required to refer, terminate, or consult if the issues are beyond our scope of practice.

Participation In Therapy

I understand that if I have any questions about my therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to sign a separate Consent for Third-Party Participation Agreement or may have to sign a separate disclosure statement in order to participate in therapy.

Consultation

The competent and ethical practice of psychotherapy dictates that I participate in a regular case consultation with other licensed professionals. These other professionals are also legally bound to keep any information discussed confidential. Should I obtain consultation regarding aspects of your treatment, I will omit identifying information (including your name, place of employment, etc.) so that your confidentiality will be preserved to the best of my ability. Your signature on this policy serves as consent that I may obtain consultation regarding your treatment (on an anonymous basis) without a specific release to do so.

Therapeutic Outcomes

There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee

of similar results with all clients

Limits of Relationship

Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of therapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to his or her relatives, friends, the relatives of friends, people known socially, or business contacts.

Termination

I understand that should I choose to discontinue therapy for more than thirty (30) days by not communicating with the Provider, my treatment will be considered “terminated.” I may be able to resume therapy after the thirty (30) day period by discussing my decision to resume therapy services with the Provider. The ability to resume therapy after thrity (30) days will depend upon my therapist’s availability and will be within his or her sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand “discontinuing therapy” means that I have not had a session with my therapist for at least thirty (30) days, unless otherwise agreed to in writing.

Affirmations

I affirm, by signing this form, I am at least twelve (12) and consent to treatment and therapy services here at Overcomers Counseling. In the event that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of twelve (12) and for whom I am requesting therapy services here at OC, I understand it is OC’s policy to seek the consent of both parents/legal guardians. Further, in the event of a custody or divorce dispute, I and the therapist must obtain the consent from the other parent/legal guardian for my minor child/ren’s treatment in accordance with DORA policy.

If I am the non-custodial parent signing this consent form for my minor child/ren’s treatment in accordance with DORA’s policy, I understand that my access to my child/ren’s treatment and client record may be limited by court order.

Emergency Contact Information

Your counselor will establish emergency contacts for you, such as a family member, a mobile phone, or a work phone number. These contacts may be used if your counselor perceives a need.

Overcomers Counseling provides non-emergency therapeutic services by scheduled appointment only. If for any reason, you are unable to contact your therapist by the telephone number provided to you and you are having a true emergency, you will call 911, check yourself in to the nearest hospital emergency room, or call Colorado’s Crisis Hotline (844) 493-8255. Overcomers Counseling does not provide after-hours

service without an appointment. If you must seek after-hours treatment from any counseling agency or center, you understand that you will be solely responsible for any fees due. You understand that if you leave a voicemail for your therapist on the phone number provided, your therapist will return the call by the end of the next business day, excluding holidays and weekends. Below are Colorado Mental Health Crisis support centers in Colorado Springs, Denver and Pueblo:

Colorado Crisis Services

Coloradocrisisservices.org

Chat online, find walk-in crisis centers, phone

Phone: 1-844-493-TALK (8255), Text TALK to 38255 to reach a trained professional.

Open 24/7

National Suicide Prevention Lifeline, 988

COLORADO SPINGS

Diversus Health

6071 East Woodmen Road, Suite 135 Colorado Springs, CO 80923

Phone: 719-572-6100

Open 24/7

Peak View Hospital

7353 Sisters Grove Colorado Springs, CO 80923

Phone: 719-444-8484

Open 24/7

Cedar Springs Hospital

2135 Southgate Rd. Colorado Springs, CO 80906

Phone: 719-633-4144

Open 24/7

DENVER

Denver Walk-In Crisis Center

4353 E. Colfax Ave Denver, 80220

Crisis Phone: (844) 493-8255, Text TALK to 38255

Open 24/7

Denver Health

777 Bannock St Denver, CO 80204

Phone: 303-602-6890

Open 24/7

PUEBLO

Health Solutions

41 Montebello Rd Pueblo, CO 81001

Phone: 719-545-2746

Open 24/7

Consent

I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist will request that I produce, in advance of commencing services with Overcomers Counseling, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. I also understand that it is Overcomers Counseling's policy to request and seek consent from both my minor

child/ren's parents, but that such consent does not supersede the Court Order Custody Agreement and/or Parenting Plan. By signing this form, I understand and consent to Company's "No Secrets" in Custody Circumstances Policy as outlined above. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

By signing this form, I affirm that I am fully informed of the therapy services I am requesting and Overcomers Counseling is providing, and grant my consent to receive such therapy services.

I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement.

Signature

Today's Date

7/3/2024

Printed Name

[redacted]

First

[redacted]

Last

Disclosure (Psychiatry)

Disclosure Statement (Psychiatry)

Client: [redacted] | **DOB**: 04/21/1992

Please review the information. If you have any questions, contact your provider. Please review the "About Me" document of your provider for specific contact information, license, and education.

Regulation Of Mental Health Professionals In Colorado

Everyone twelve (12) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must sign this disclosure statement on behalf of their minor child under the age of twelve (12) years old. In accordance with best practices, the Mental Health professional will encourage the participation of client's parents for youth under the age of 15. Additionally, the mental health professional may notify the parent or legal guardian, without the minor's consent, if in their professional opinion the minor is unable to manage their own care or treatment, or if the minor expresses any suicidal ideation.

In divorce or custody situations and because of the Colorado Department of Regulatory Agencies view on parental consent, it is the Provider's policy to seek the consent of both parents/legal guardians, however, this consent does not supersede any court order outlining parental decision-making and custodial rights. This policy is irrespective of any court determination and this is the governing policy unless the child's health, safety, and welfare could be at risk. If this is the case, you must inform the Provider so that appropriate action for the protection and welfare of the child may be taken. This disclosure statement contains the policies and procedures of the Provider and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your provider.

The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Nursing regulates Psychiatric Mental Health Nurse Practitioners, and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through OC's internal process.

You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your provider.

Client Rights And Important Information:

OC provides psychotropic medication management and the scope this service is as follows:

Psychotropic Medication Management:

Medication management services include an initial intake evaluation with a board certified psychiatric nurse practitioner (PMHNP-BC) who has prescriptive authority (ability to prescribe psychiatric medication) in the state of Colorado. The initial intake appointment is required, as this is the appointment where at least 60 minutes is designated to comprehensively review your psychiatric and medical history, current/recent symptoms, and to identify your diagnosis and potential treatment options. Based on information gathered at your intake appointment, your psychiatric nurse practitioner may recommend the use of psychiatric medications to treat your diagnosis. Should medications be used, your provider will review potential risks, benefits, and side effects of each medication/option and will obtain your verbal understanding and consent for treatment prior to implementing the plan. In addition to the use of medication, your prescriber may recommend additional treatment modalities to aid in symptom reduction including but not limited to the use of talk therapy, exercise, or nutritional counseling. All treatment is a joint active effort between the client and OC, and your treatment plan will be updated as we work together.

As a client you are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, if I can determine it, and my fee structure. Please ask if you would like to receive this information.

Prescription Refills:

If you begin taking a medication, it is important that you are safely monitored for its effectiveness and for side effects. You will be given ample medication and refills until your next appointment. It is your responsibility to schedule follow-up appointments before you run out of your prescription. In return, you will find that OC is conscientious about the cost of medical care and will not request unnecessary visits.

Fees:

My fee structure, services, and fee policy are outlined as follows:

1. $300.00 Psychiatric Medication Management
2. It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a “Credit Card Authorization” form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.
3. I am a Medicaid provider. If you have Medicaid coverage that includes mental health services, I am able to offer mental health services to you.
4. Legal Services incurred on your behalf are charged at a higher rate including but not limited to:

attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $420.00 per hour.

Restrictions on Uses:

You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however OC is not required to agree to a restriction request. Please review OC's Notice of Privacy Policies for more information.

Second Opinion and Termination:

You are entitled to seek a second opinion from another provider or terminate therapy at any time.

Sexual Intimacy:

In a professional relationship (such as psychiatry), sexual intimacy between a psychiatrist/nurse practitioner and a client is never appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Nursing.

Confidentiality:

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the psychotherapist is a Licensed Psychologist, Licensed Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Certified and Licensed Addiction Counselor, or a Unlicensed Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-43-218. You should be aware that provisions concerning disclosure of confidential communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations

that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out OC's Consent for Communication of Protected Health Information by Unsecure Transmissions.

"No Secrets" Policy:

When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (i.e on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless your provider is required to do so by law. However, in the event that you disclose information that is directly related to the treatment of the couple or family it may be necessary to share that information with the other members of the couple or the family in order to facilitate the therapeutic process. Your provider will use her best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, your provider will first give the individual the opportunity to make the disclosure themselves. This "no secrets" policy is intended to allow your provider to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the couple or the family being treated. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate provider who can treat you individually.

"No Secrets" in Custody Circumstances Policy:

When treating a Client who is a Minor under the age of fifteen (15) and where there exists a custody arrangement between the parents or legal guardians (such as a divorce or separation), it is my policy to communicate with both parents/guardians via email (i.e. all communication will "cc" both parties). This policy is necessary to maintain transparency and professionalism, and to ensure the well-being of the therapeutic relationship with the Minor Client. This policy does not supersede any court order outlining decision-making or custodial rights but is or may be required by DORA. Further, I reserve the right, in my sole discretion, to engage in any individual email communication or face-to-face interaction in the lobby/waiting area. In the event that such an interaction occurs, I will notify the other party of said interaction and summarize the contents of the conversation, unless prohibited by professional rules or regulations regarding the protection of the health, safety, and welfare of the child/ren.

Contacting You:

It is your responsibility to keep your contact information up to date so that we can reach you when needed. If your information changes, to include insurance, please notify OC as soon as possible.

Contacting Your Provider:

You are encouraged to contact your provider if you have questions or concerns about your treatment. Communication is most effective via your HIPAA secure patient portal, which will be responded to within 24 business hours. If you are unable to send a message through your patient portal, you may leave a message including your name, phone number, and description of the matter you are calling about at (719) 504-4404. Appointments will not be interrupted to take calls during the day, and voicemails will be returned within 72 business hours. Please do not leave a message via your patient portal or through voicemail if you are having a medical or mental health emergency. In this event please call 911.

Through your patient portal you can leave non-emergent messages for your provider, change or cancel an appointment, submit refill requests for current medications, and access your health records.

Extraordinary Events:

In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter “extraordinary event,”) the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: Jennifer Luttman, LPC

ADDRESS: 5585 Erindale Dr. Ste. 204 Colorado Springs, CO 80918

TEL: (719) 345-2424 x700

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Maintenance of Client Records:

As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of the State Board of Nursing, OC will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later. OC cannot guarantee a copy of your Client Record will exist after this seven-year period.

Electronic Records:

OC may keep and store client information electronically on OC’s laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, OC may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. OC may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

OC may use electronic backup systems such as external hard drives, thumb drives, or similar methods. If such backup methods are used, reasonable precautions will be taken to ensure the security of this

equipment and it will be locked up for storage. OC uses a cloud-based service for storing or backing up information. The cloud-based backup system OC uses is: TherapyNotes and the email service provider OC uses is: Gmail. OC may maintain the security of the electronically stored information through encryption and passwords. In addition, in order to maintain security of the electronically stored information OC has employed the following security measures:

- Entered into a HIPAA Business Associates Agreement with the cloud-based company and email service provider. Because of this Agreement, the cloud-based company and email service provider are obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.
- The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- The cloud-based company and email service provider employ various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the cloud-based company or email service provider's workforce members, in order to maintain the system itself. Federal law protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures OC employs, please ask.

Availability and Response Policy:

My normal business hours are vary. However, as a therapist, the majority of my business hours are devoted to seeing my clients in therapy, which means I am not always available for immediate contact via phone, text, or email. This is especially true for emergencies, as I am not equipped to respond immediately.

The best way to contact me is via email. Every effort will be made to respond to you in a clear and timely manner. Voicemails sent to 719-345-2424 will be returned within 48 hours, excluding Saturdays, Sundays, and holidays. Emails sent to support@overcomewithus.com will be returned within 48 hours, excluding Saturdays, Sundays, and holidays. I also reserve the right, in my sole discretion, to return communication outside of these hours; but any communication which I initiate outside of these normal business hours is in no way a guarantee or a promise of availability outside of my normal business hours.

Disability Evaluations and Service Animals:

The goal of OC is to work with you to improve your symptoms and overall mental health, and for your diagnosis not to interfere with your functioning. Because of this goal, OC does not do disability evaluations or recommendations of any type, or for any circumstances. OC additionally does not provide letters of recommendation for emotional support pets or service animals.

As A Client:

You as a Client agree and understand the following:

1. I understand that OC may contact me to provide appointment reminders or information about

treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with OC's Consent for Communication of Protected Health Information by Unsecure Transmissions.

2. I understand that if I initiate communication via electronic means that I have not specifically consented to in OC's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my provider may communicate with me via this method.
3. I understand that there may be times when my provider may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my provider and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my provider permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my provider.
4. OC employs the use of telehealth to reduce barriers in receiving mental health care, which may include geographical obstacles (i.e. rural location), or time restrictions (i.e. the busy working adult, school for kids). Telemedicine (also called telehealth or telepsychiatry) is care provided via the use of a live two-way video interaction between the client and provider through a HIPAA secure internet connection. OC uses TherapyNotes and Google Meets as the telehealth platform.

Location for Receiving Medication Management Services:

Due to the complex nature that can accompany prescribing some (not all) medications for mental health diagnoses, the first medication management appointment is required to be in-office. After your first appointment, if your provider feels it to be appropriate you may receive follow up appointments from the comfort of your own home or other private location via remote televideo connection. If you are prescribed a controlled substance you will be required to have an in-office appointment at least once every 6 months, or more often if recommended by your provider. I understand that as a prerequisite for receiving medication management via TherapyNotes or Google Meets, I may be required to provide live electronic data regarding blood pressure and heart rate using an electronic auto-cuff and I may be required to visit with my primary care doctor (PCP). In addition, I agree to provide written consent for my mental health provider to communicate with and notify my PCP of current psychiatric medications and treatment plan changes. This is a safety precaution related to limited ability to monitor blood pressure and pulse "in-person", and for enhanced collaborative care.

1. I understand that my provider, does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that OC has, or may have, a business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" OC's business social media page that others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on OC's page/wall as well. I understand that any comments I post regarding therapeutic work between my provider and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my provider through the mode I consented to and not through social

media.

2. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my provider and address those questions.
3. I understand my provider provides non-emergency therapeutic services by scheduled appointment only. If, for any reason, I am unable to contact my provider by the telephone number provided to me, 719-345-2424, and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. OC does not provide after-hours service without an appointment. If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due. I understand that if I leave a voicemail for my provider on the phone number provided, my provider will return my call by the end of the next business day, excluding holidays and weekends.
4. If my provider believes my therapeutic issues are above her level of competence or outside of her scope of practice, my provider is legally required to refer, terminate, or consult.
5. I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my provider, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my provider to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my provider about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my provider's entire client file. I understand that once my insurance company receives the information I or my provider has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my provider a copy of any report OC submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.

Medicaid Providers:

1. Health First Colorado Member Billing Providers agree to accept the Health First Colorado payment as payment in full for benefits. Colorado law (C. R. S. 25.5-4-301 (II)) provides that no Health First Colorado member shall be liable for the cost, or the cost remaining after payment by Health First Colorado, Medicare or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error, and whether or not the provider is enrolled in the Health First Colorado. This law applies even if a Health First Colorado member agrees to pay for part or all of a covered service. This law also prohibits providers from billing Health First Colorado members for the estates of deceased Health First Colorado members for Health First Colorado benefits. As such, Health First Colorado members are not responsible for payment for late cancellations or failure to show for an appointment.
2. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.
3. I understand that if I have any questions about my provider's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy

process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my provider. I agree that these parties will have to sign a separate Consent for Third-Party Participation Agreement or may have to sign a separate disclosure statement in order to participate in therapy.

4. I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with OC or my provider, my treatment will be considered “terminated.” I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with OC. Ability to resume therapy after sixty (60) days will depend upon my provider’s availability and will be within her sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand “discontinuing therapy” means that I have not had a session with my provider for at least sixty (60) days, unless otherwise agreed to in writing.
5. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.
6. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of provider and client. This means that my provider cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to her relatives, friends, the relatives of friends, people known socially, or business contacts.
7. I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice (“no-show”), excluding emergency situations, my provider has a right to charge my credit card on file, or my account, for the full amount of my session.
8. Repeated no-shows or late cancellations will be discussed and may because to discontinue treatment. Please note that appointment reminders are a courtesy only, and it is ultimately your responsibility to remember the date and time of your appointment.
9. Your provider will strive to complete all work during scheduled sessions. In order to remain courteous to other patients by staying on schedule, if you are late for your appointment you will only be seen for the time allotted and will be charged for a full appointment. If you are more than 15 minutes late for your appointment, you may not be able to be seen and will be charged for the full appointment time.
10. I also affirm, by signing this form, I am at least fifteen (15) years old and consent to treatment and therapy services here at OC. In the event that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15) and for whom I am requesting therapy services here at OC, I understand it is OC’s policy to seek the consent of both parents/legal guardians. Further, in the event of a custody or divorce dispute, I and the therapist must obtain the consent from the other parent/legal guardian for my minor child/ren’s treatment in accordance with DORA policy.
11. If I am the non-custodial parent signing this consent form for my minor child/ren’s treatment in accordance with DORA’s policy, I understand that my access to my child/ren’s treatment and client record may be limited by court order.

12. I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist will request that I produce, in advance of commencing services with OC, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. I also understand that it is OC's policy to request and seek consent from both my minor child/ren's parents, but that such consent does not supersede the Court Order Custody Agreement and/or Parenting Plan. By signing this form, I understand and consent to OC's "No Secrets" in Custody Circumstances Policy as outlined above. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.
13. By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that OC is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my provider, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my provider.

Signature

Today's Date

7/3/2024

Printed Name

First

Last

HIPAA Notice of Privacy

Client: [redacted] | **DOB**: 04/21/1992

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

Your Choices

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

- In emergency situation, tell family and friends about your condition
- Provide mental health care

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

- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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

If you are emotionally or cognitively not able to tell us your preference 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
- Most sharing of psychotherapy notes

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 therapist treating you for anxiety asks your Primary Care Physician 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.

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
- 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.

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.

Other Instructions for Notice

- This notice is effective on or after 1 May 2019.
- Overcomers Counseling privacy contact: privacy@overcomewithus.com
- We never market or sell personal information.
- We conform to all applicable state laws, rules, and regulations pertaining to client privacy in all states in which we do business.

Signature

Today's Date

7/3/2024

[redacted]

Printed Name

[redacted]

First

[redacted]

Last

Telehealth Informed Consent

Telehealth Informed Consent

Client: [redacted] | **DOB**: 04/21/1992

I hereby consent to the use of teletherapy. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations, and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

- I, the client, need to be a resident of Colorado. (This is a legal requirement for therapists practicing in this state under a CO license.)
- I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the Disclosure Statement.
- I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- There is a risk that services could be disrupted or distorted by unforeseen technical problems.
- In addition, I understand that teletherapy-based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.
- I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy
- I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24-hour hotline support.
- Clients who are actively at risk of harm to themselves or others are not suitable for teletherapy services. If this is the case or becomes the case in the future, my therapist will recommend more

appropriate services.

- I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment, and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.
- I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

In case of emergencies, loss of internet connection, etc. I consent for my provider to reach out to my emergency contact to confirm safety if for any reason we are disconnected.

I have read, understand, and agree to the information provided above regarding telehealth.

Signature

Today's Date

7/3/2024

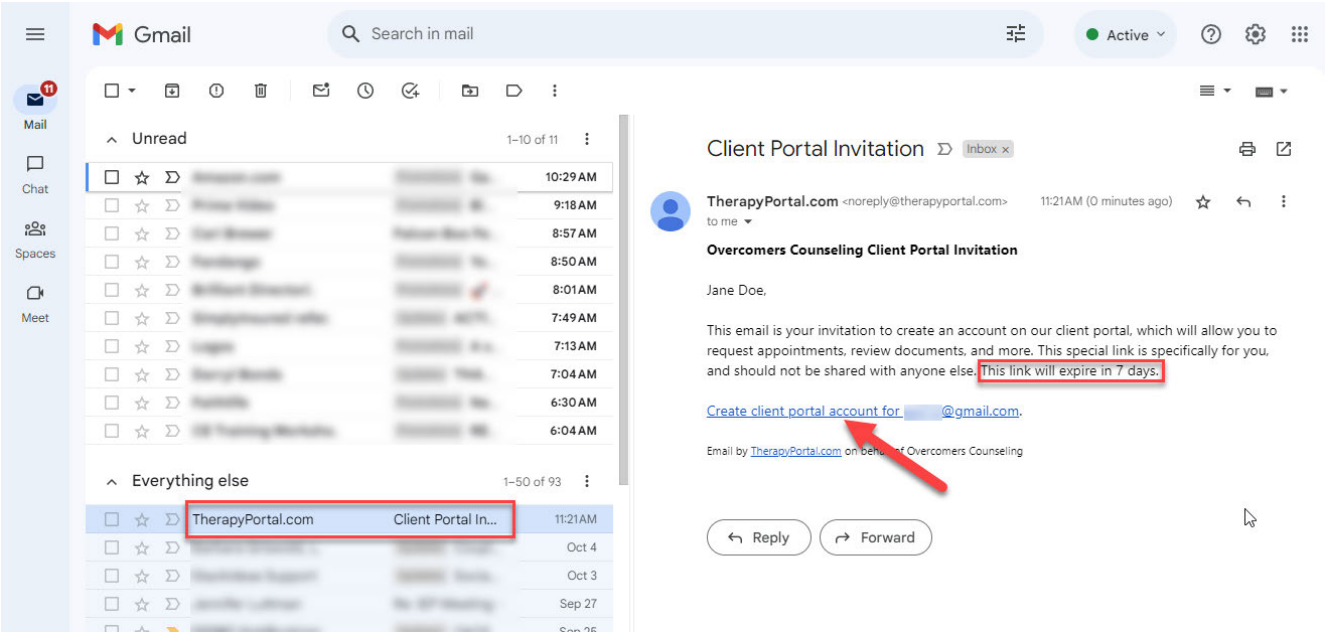
Printed Name

First

Last

How Teletherapy Works at Overcomers

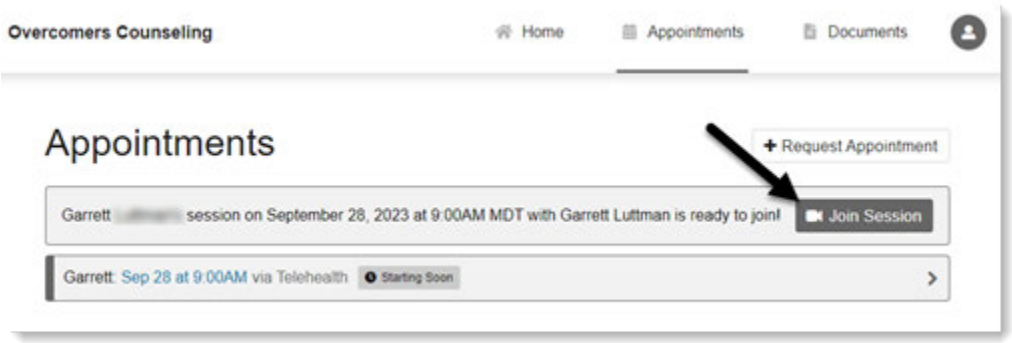
After submitting this Intake Packet, our Scheduling Team will review and send you an Invite (to your **email**) to the Client Portal. **YOU MUST CREATE A PORTAL ACCOUNT BEFORE THE LINK EXPIRES.**



In the client portal, you can:

- manage your appointments,
- view your treatment plan,
- pay balances and
- join your telehealth session.

Log in and click the button shown before the telehealth appointment begins. Here's an example:



Provider Background

Provider Background

Client: [redacted] | **DOB:** 04/21/1992

To view our provider's "About Me" document and read their background information and contact information - **CLICK HERE**

Your Provider

Vanessa Curran, LPCC

Provider's Contact Info

- vanessa.curran@overcomewithus.com
- (719) 396-6701
- View your provider's background and license.

Get details about the location of your appointment

Virtual

- Colorado

Select the location name of your session to reveal more details.

☑ I have read the background, education, and contact information of my provider.

Signature

[redacted]

Today's Date

7/3/2024

Printed Name

[redacted]

First

[redacted]

Last

GAD-7

GAD-7

Client: [redacted] | DOB: 04/21/1992

1. Feeling nervous, anxious or on edge
○ 0 - Not at all ○ 1 - Several days ○ 2 - More than half the days ⊙ 3 - Nearly everyday

2. Not being able to stop or control worrying
○ 0 - Not at all ○ 1 - Several days ○ 2 - More than half the days ⊙ 3 - Nearly everyday

3. Worrying too much about different things
○ 0 - Not at all ○ 1 - Several days ○ 2 - More than half the days ⊙ 3 - Nearly everyday

4. Trouble relaxing
○ 0 - Not at all ○ 1 - Several days ○ 2 - More than half the days ⊙ 3 - Nearly everyday

5. Being so restless that is is hard to sit still
○ 0 - Not at all ○ 1 - Several days ⊙ 2 - More than half the days ○ 3 - Nearly everyday

6. Becoming easily annoyed or irritated
○ 0 - Not at all ○ 1 - Several days ⊙ 2 - More than half the days ○ 3 - Nearly everyday

7. Feeling afraid as if something awful might happen
○ 0 - Not at all ○ 1 - Several days ○ 2 - More than half the days ⊙ 3 - Nearly everyday

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people

Very difficult

When did symptoms begin?

I always have a low level of anxiety, lately it has been much worse with the age and health of my dogs and my husband having a job at night. My isolation is becoming a problem

Signature

Today's Date

7/3/2024

[redacted]

PHQ-9

PHQ-9

Client: [redacted] | DOB: 04/21/1992

Over the last 2 weeks, how often have you been bothered by the following problems?

	0 - Not at all	1 - Several days	2 - More than half the days	3 - Nearly everyday
1. Little interest or pleasure in doing things	○	○	○	⊙
2. Feeling down, depressed, or hopeless	○	○	○	⊙
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	⊙
4. Feeling tired or having little energy	○	○	○	⊙
5. Poor appetite or overeating	○	○	○	⊙
6. Feel bad about yourself - or that you are a failure or have let yourself or your family down	○	○	○	⊙
7. Trouble concentrating on things, such as reading the newspaper or watching televison	○	○	○	⊙
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	○	○	⊙	○
9. Thoughts that you would be better off dead, or hurting yourself in some way	⊙	○	○	○

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people

Very difficult

Signature

Today's Date

7/3/2024