

Client Name: _____ Insurance ID: _____

Stewart Behavioral Health

Patient Information

Date: _____ New Pt. _____ Update _____

Client's Legal Name/Nickname: _____

Sex: _____ Age: _____ Race: _____ Date of Birth: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternative Phone: _____

Email: _____

Reminders (circle one): **Email:** Yes No **Text Message:** Yes No

Employment Status (circle one): Employed Unemployed/Other Student

Marital Status (circle one): Single Married Divorced Other

Emergency Contact Information

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

Insurance Information

Client's Insurance Plan Name: _____ ID#: _____

Name on Insurance Card: _____ Insured's Birthday _____

Relationship to Pt: _____

***Secondary Insurance Information* (Skip if not applicable)**

Client's Insurance Plan Name: _____ ID#: _____

Name on Insurance Card: _____ Insured's Birthday _____

Relationship to Pt: _____

Client Name: _____ Insurance ID: _____

Patient Consent- Payment Authorization- Signature on File

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I will let the staff know at the next appointment without fail. I hereby authorize payment directly to Stewart Behavioral Health. If I have provided my insurance information above, I hereby authorize Stewart Behavioral Health to bill my insurance for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: _____ **Date:** _____

Please read each section carefully and sign or initial as indicated:

Thank you for choosing Stewart Behavioral Health, LLC. This document is intended to inform you of our policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and we will do our best to provide you with information you need.

Mission Statement:

At Stewart Behavioral Health (hereinafter may be referred to as SBH), we are dedicated professionals committed to providing quality counseling services. It is our overall goal to enhance the quality of life for individuals and families at all stages of life. Our belief is that all people are valuable and unique and should be treated with dignity and respect. We strive to uphold a caring, confidential, and professional environment to support clients throughout the counseling process.

Scheduling and Appointments:

Office hours may vary depending on the provider that you work with. We have several providers that provide services and with that we typically can offer times that may accommodate most clients. We cannot guarantee that the available schedule may accommodate all clients but, if this occurs we will support the client by providing alternative options.

Administrative staff is available 10:30 A.M.- 6 P.M. Mondays through Fridays

Throughout the day, we check our messages regularly, and whenever possible we try to return calls the same day. If we have not returned your call within 24 hours, please try again. We strive to meet all our clients' needs within our scope of practice and your communications are important and valued.

Management Contact Information:

Clinical Director: Martha Stewart, mstewart@stewartbehavioralhealth.com
Office Manager: Randa Abbott, rabbott@stewartbehavioralhealth.com

Client Name: _____ Insurance ID: _____

Foster Care Information

Is this child currently in foster care?

YES NO

If yes, please complete the following:

Foster Mother's Name: _____ Foster Father's Name: _____

Phone Number: _____ Phone Number: _____

Caseworker's Name: _____ Agency: _____

Phone Number: _____

Kinship Agreement Information

Is there a current DSS kinship agreement in place?

YES NO

If yes, please complete the following:

Kinship Caregiver's Name(s): _____

Phone Number: _____

Guardianship, Custody, and Rights to Mental Health Information

Is there a current court order in place giving anyone other than the biological parents guardianship, custody, or rights to client mental health information?

YES NO

Required Documentation

❖ Our office requires a copy of any **current custody, visitation, guardianship orders**, or **active DSS kinship agreements** to be on file prior to the client seeing the counselor.

Signature and Acknowledgment

By signing this form, I am agreeing that all the information provided is correct to the best of my knowledge. I further understand that this sheet is only for informational purposes for this office. If I wish to sign a release for anyone listed on this form, I will complete a separate release of information form. *(Please ask the front office staff for an additional release form should you require one.)*

Client or Parent/Guardian Signature: _____ **Date:** _____

Client Name: _____ Insurance ID: _____

Ethics:

SBH follows the Code of Ethics of the South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists.

Some ethical considerations are:

- **At SBH, we dedicate ourselves to serving the best interests of each client.**
- **At SBH, we will not discriminate against clients or professionals based upon age, race, creed, disabilities, handicaps, preferences, or other personal concerns.**
- **At SBH, we are committed to maintaining an objective and professional relationship with each client. Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned.**
- **At SBH, we respect the rights and views of other mental health professionals.**
- **At SBH, we will appropriately end services or refer clients to other programs when necessary or in the best interest of the client.**
- **At SBH, we will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purposes of quality treatment for our clients and self-improvement as professionals. We will continually attain further education and training.**
- **At SBH, we respect various institutional and managerial policies but are committed to assisting in improving such policies if this is in the best interest of the client.**
- **Please note that if you believe that any of your rights have been violated, we will gladly direct you to the necessary agency to address your concerns,**

Initials indicate that you have read and agree: _____

****EMERGENCY PROCEDURES****

If an emergency occurs while you are not at SBH, please call emergency services (911). If you would like to contact your counselor regarding your situation, you may call the office at (843) 407-5419 at your convenience. SBH will follow those emergency services with standard counseling and support to the client and/or to the family of the client. If an emergency occurs while you are at SBH, we will call emergency services (911).

Crisis prevention intervention is a verbal and/or physical de-escalation. If something occurs during a session involving a client becoming agitated/aggressive/violent, our first attempt will be to verbally de-escalate the situation. If that fails, the counselor or front office staff will contact emergency services (911) to diffuse the situation. If you want more information on our procedures, please ask to see our "Policies and Procedures Manual."

In the event of an emergency, I agree to call 911 or report to the nearest Emergency Department for treatment. I will notify my counselor of any emergencies.

Signature (Client/Parent/ Legal Representative)

Date

Client Name: _____ Insurance ID: _____

Confidentiality:

The information that you share in psychotherapy is protected health information (PHI) and is considered confidential by both South Carolina statute law and federal regulations. Exceptions to confidentiality include:

1. Revealing intent to harm self or others.
2. Abuse of a child, the elderly or medically vulnerable.
3. Intent to commit a crime.
4. If my counselor is provided a court order.
5. For billing purposes if a Release of Information is granted by client or guardian.
6. If a Release of Confidential Information is endorsed by a client or caregiver.
7. Consultation, Supervision: Information about you may be discussed in confidence, without revealing your identity, with other counseling professionals for the purpose of consultation and providing you the best possible service. If you are working with a Licensed Professional Counselor Intern or Licensed Clinical Social Worker Intern, your clinical mental health counselor is required to discuss your case on a regularly scheduled basis with his/her supervisor. This will include your name, diagnosis, and content of therapy. The Supervisor is also required to maintain your confidentiality under the same legal guidelines as your clinical mental health counselor

Also, there may be times that an intern will be asked to observe and/or participate in a session for the purpose of enhancing your treatment and the profession. Please be aware that you may refuse to have an intern in your session at any time.

If applicable, your clinical mental health counselor will complete the following for your information:

I am being supervised by:

_____ Martha Stewart, LPC, LPC-S

_____ Tyler Stricklin, LPC-candidate

Please note that a specific Consent for Release of Information may be revoked by writing to our privacy officer. You may ask any staff member for assistance in this area. However, please be aware that information may have been shared prior to the date of revocation, and this cannot be changed.

Additionally, SBH may need to disclose PHI for purposes of treatment such as coordination and consultation or for general healthcare operations. This may be a requirement for some certification, compliance, and licensing procedures. Information may also be shared with law enforcement, should a crime be committed on our premises or against our staff.

Initials indicate that you have read and agree: _____

Client Name: _____ Insurance ID: _____

Informed Consent:

Your signature verifies that you have been offered a copy of this document and the HIPPA document.

Further you need to be aware:

- Treatment is not always successful and may open unexpected emotionally sensitive areas.
- Counselors with SBH are not physicians and cannot prescribe medications.
- Counselors with SBH may need to consult with your physician, attorney, or other counselor.
- Counselors with SBH are not available 24 hours a day
- Counselors with SBH are licensed through the SC Board of Examiners for the Licensure of Professional Counselors, Marriage and Family Therapist, and Psycho-educational Specialists; this Board is located in The Synergy Center (Kingstree Building) in Columbia, SC at (803) 896-4652. Mailing address is P.O. Box 11329 Columbia, SC 29211-1329

Initials indicate that you read and agree: _____

In the event of your counselor's death or disability, SBH may designate a proper custodian to be responsible for the care of your records.

Initials indicate that you have read and agree: _____

Consent for Treatment

In signing the following agreement, I am consenting to participate in counseling services. I agree to attend scheduled counseling appointments. I understand that counseling appointments are dependent on a case-by-case basis, sometimes ranging from 30 minutes to 90 minutes.

Initials indicate that you read and agree: _____

Client Name: _____ Insurance ID: _____

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AND USE OF INSURANCE FOR REIMBURSEMENT OF SERVICES

SBH has my permission to provide services to myself/my child and to release and exchange medical, psychological, and other personally-identifiable and confidential information, as necessary, to my insurance provider(s) regarding billable services provided. I understand that the purpose of this consent is to bill my insurance provider for services rendered by SBH on my/my child's behalf.

Insurance Reimbursement

SBH accepts and processes insurance payments through a variety of insurance and Employee assistance plans. If you are using insurance or Employee assistance to pay for services, The we will:

1. Expect and accept payment of your copayment amount at the time of service;
2. File your claim with the primary insurance provider;
3. Receive payment from your insurance provider;
4. Expect that you will pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your appointment.

By signing this form, I am giving SBH permission to bill and receive payment.

Client name (please print)

Client/Guardian Signature

Date

Witness Signature

Payments:

Payment is due at the time of your session, unless other arrangements have been made in advance. Our office will submit claims to your primary in-network insurance, but you are responsible for any deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefits. If claims are denied, your coverage has been terminated, or if you are in your HIX grace period due to lack of premium payments with your insurance company, you are responsible for paying your account in full. Our administrative staff will be happy to assist you with any questions, comments or concerns that you may have.

Private/Self -Payment for Services

I will self-pay for services at SBH. I agree to the fee schedule in this document. I understand that payment for services is due at the time of services are provided.

Client or Parent/Guardian Signature **Date** _____

Client Name: _____ Insurance ID: _____

Fee Agreement and Financial Policy

Fees:

It is customary to pay for professional services at the time they are rendered. We accept various forms of insurance, cash, checks and credit/debit cards and will provide a receipt upon request. You are responsible for any fees that may be incurred as a result of participating in counseling services.

Associated fees may vary depending on the type of services rendered. A schedule of fees is available upon request. If you fail to pay or are unable to pay, we may refer you to another provider.

Initials indicate that you have read and agree: _____

Service Rates and Corresponding Health Insurance Billing Codes

This list includes the most commonly provided services by our practice. Your counselor may use additional codes as necessary based on your needs.

- **90791** Initial Intake (45-60 minutes) – \$165
- **90837** Individual Therapy (53-60 minutes) – \$125
- **90834** Brief Individual Therapy (38-45 minutes) – \$100
- **90832** Brief Individual Therapy (25-30 minutes) – \$40
- **90847** Family Therapy with Client (50 minutes) – \$125
- **90846** Family Therapy without Client (50 minutes) – \$125

Clients are responsible for paying for the full duration of the session they schedule. If you arrive late or leave early, you will be responsible for any portion of the session not covered by your insurance.

Initials indicate that you read and agree: _____

Charges Not Covered by Insurance

- **Medical Records Requests** \$.65 per page for the first 30 pages
\$.50 per page for all other pages
Clerical fee not to exceed \$25.00
(may only apply once)
Max fee: \$150.00
Plus actual postage and applicable sales tax
- **Phone Consultations** \$15 per 15 minute increments

Additional fees

- Processing Fee for Credit/Debit Cards 3.5%
- Non-sufficient funds (bounced) check \$35

*Includes checks returned due to insufficient funds

Client Name: _____ Insurance ID: _____

- Amounts past due by more than 30 days will incur a late fee each month of \$25.00. If your account has not been paid for more than 45 days and arrangements have not been agreed upon, Stewart Behavioral Health may resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, If such a legal action is necessary, you will be responsible for those costs.

Client or Parent/Guardian Signature _____ **Date** _____

Missed Appointment Agreement

Effective March 28th, 2025

At SBH, we are committed to working with you to help you achieve your goals. We value your time, and your appointment is reserved specifically for you. When you miss an appointment, it impacts the counselor's schedule, as they are not compensated for that time. As such, there are fees associated with missed appointments.

Starting on **March 28th, 2025**, the missed appointment fees are as follows:

- The first missed appointment: \$50.00
- The second missed appointment: \$90.00, which will remain the fee for any further missed appointments.

*Please note, we are unable to bill your insurance for missed appointments, so you are responsible for paying these fees. You will not be able to reschedule any future appointments until the missed appointment fees are paid in full. Medicaid clients are not charged for missed appointments; however, after two missed appointments, Medicaid clients may be referred back to their referral source.

If you miss an appointment and do not notify our office, our system will automatically remove any future appointments you have scheduled. This also includes appointments for which you are the guarantor.

*Provide at least 24 hours' notice if you need to cancel or reschedule. Cancellations with less than 24 hours' notice will still count as a missed appointment. You can always leave a message on our secure voicemail system, available 24/7, if calling outside of regular business hours.

Missed appointment fees cannot be waived. If you have any questions, please reach out to the office for assistance.

Initials indicate that you read and agree: _____

Client Name: _____ Insurance ID: _____

Emergencies

_____ (Initial) In the event of an emergency, call 911 or proceed to your local emergency room, we are not a crisis clinic.

Court Reports and Sessions

_____ (Initial) We do not go to court sessions. With a proper release of information we will supply letters, reports, etc. for court.

Medical Records Requests

_____ (Initial) When a Medical Record Request is made, the standard timeline is forty-five (45) days. SC DHEC sets the cost for this service. Page 1-30 is \$0.65 per page, pages 31+ is \$0.50 per page. The clerical fee is set at \$25.00 for this service.

Communication Policy

_____ (Initial) In the age of social media and electronic communication, there are no forms of communication that can be guaranteed to be confidential. HIPAA does not consider cell phone communications confidential. As a result, we suggest that you limit our electronic communications to billing or scheduling issues. By initialing this consent, you agree to accept the risk of limited confidentiality for information transmitted via text or email.

_____ (Initial) Social media invitations or friend requests cannot be accepted by a therapist. If you choose to comment on a public site and identify yourself as a client, then you forgo your right to confidentiality.

_____ (Initial) If your therapist encounters you in a public setting, they will not acknowledge you to protect your confidentiality.

My signature below confirms that I understand and accept all the information contained in the **Stewart Behavioral Health Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights**.

- I am aware of its contents and policies and understand that a copy of this Signature Statement will be a part of my case record.
- I have read it and if necessary, I have discussed and clarified my understanding of it with a representative of SBH.
- I agree to abide by the terms/policies set forth in this document.
- I consent to have the above-named minor(s) receive therapeutic services provided through Stewart Behavioral Health, LLC without a parent or guardian present.

Client name (please print)

Client/Guardian Signature _____ **Date** _____

Witness Signature _____ **Date** _____

**The majority of this document is mandated by both South Carolina State law and Public Law 104-191.

Client Name: _____ Insurance ID: _____

Card Holder Authorization

Upon scheduling your first appointment you have the option to provide credit card information which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance, deductibles, late cancellations, missed appointments, returned checks, balances due from sessions, or past due account balances. **A signed card holder authorization is required to run a card via telephone without the card present.** A receipt can be emailed to you at your request.

Clients participating in telehealth sessions **must** have a card on file 48 prior to the telehealth sessions in order for the session to be completed.

Type of card (circle one)

VISA Mastercard American Express Discover

Card#: _____ - _____ - _____ - _____

Expiration: __/__

Security Code: _____

Zip Code: _____

Name on Card: _____

I authorize Stewart Behavioral Health to charge this credit card as needed according to the terms specified in this Agreement Policy.

Signature of Card Holder: _____ Date: _____

Client Name: _____ Insurance ID: _____

Consent for Use of Artificial Intelligence (AI)

As part of their ongoing commitment to provide the best possible service, your provider has opted to use an artificial intelligence note-taking tool that assists in generating clinical documentation based on your sessions. This allows for more time and focus to be spent on our interactions instead of taking time to jot down notes or trying to remember all the important details. A temporary recording and transcript or summary of the conversation may be created and used to generate the clinical note for that session. Your provider then reviews the content of that note to ensure its accuracy and completeness. After the note has been created, the recording and transcript are automatically deleted.

This artificial intelligence tool prioritizes the privacy and confidentiality of your personal health information. Your session information is strictly used for the purpose of your ongoing medical care. Your information is subject to strict data privacy regulations and is always secured and encrypted. Stringent business associate agreements ensure data privacy and HIPAA compliance. Please discuss any questions or concerns you may have about this feature with your provider.

By signing this form, you consent to the use of artificial intelligence as described. You acknowledge that your participation is voluntary and not a condition of receiving services from your clinician, and that you can withdraw your consent at any time.

I have read, understood and agree to the items contained in this document.

Client or Parent/Guardian Signature _____ **Date** _____

Client Name: _____ Insurance ID: _____

This section below is completed for minors only

**If Student, Please complete: ___ Full Time ___ Part Time

School/Location _____

This office understands that often extended family members and friends help many of our families with minor children. A legal guardian is required to sign for a minor client to enter counseling with our office. This information is provided to help us better protect your privacy. Please only fill out what pertains to your case:

Biological Parent(s)

Mother's Name: _____ Father's Name: _____

Phone Number: _____ Phone Number: _____

Biological Parents Are:

Married Separated Divorced Cohabiting Not married, living separately

If living separately, please tell us who the child lives with the majority of the time:

If Biological Parent(s) Are Divorced and Still Have Custody:

Please tell us if either parent has remarried and provide the stepparent's names:

Stepmother's Name: _____ Stepfather's Name: _____

Phone Number: _____ Phone Number: _____

Termination of Parental Rights

Has there been a termination of rights for either or both biological parents?

YES NO

If yes, please enter the parent(s) name(s):

Adoption Information

Was there an adoption for this client?

YES NO

If yes, please enter the date of adoption: _____

Adoptive Mother's Name: _____ Adoptive Father's Name: _____

Phone Number: _____ Phone number: _____

DSM-5-TR Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____

Age: _____

Date: _____

Relationship with the child: _____

Instructions (to the parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past **TWO (2) WEEKS**.

| | | None Not at all | Slight Rare, less than a day or two | Mild Several days | Moderate More than half the days | Severe Nearly every day | Highest Domain Score (clinician) |
|-------|-----|--|--|-------------------------------------|---|----------------------------------|---|
| | | During the past TWO (2) WEEKS , how much (or how often) has your child... | | | | | |
| I. | 1. | 0 | 1 | 2 | 3 | 4 | |
| | 2. | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. | 0 | 1 | 2 | 3 | 4 | |
| IV. | 5. | 0 | 1 | 2 | 3 | 4 | |
| | 6. | 0 | 1 | 2 | 3 | 4 | |
| V. & | 7. | 0 | 1 | 2 | 3 | 4 | |
| VI. | 8. | 0 | 1 | 2 | 3 | 4 | |
| VII. | 9. | 0 | 1 | 2 | 3 | 4 | |
| | 10. | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 11. | 0 | 1 | 2 | 3 | 4 | |
| | 12. | 0 | 1 | 2 | 3 | 4 | |
| | 13. | 0 | 1 | 2 | 3 | 4 | |
| IX. | 14. | 0 | 1 | 2 | 3 | 4 | |
| | 15. | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. | 0 | 1 | 2 | 3 | 4 | |
| | 17. | 0 | 1 | 2 | 3 | 4 | |
| | 18. | 0 | 1 | 2 | 3 | 4 | |
| | 19. | 0 | 1 | 2 | 3 | 4 | |
| | | In the past TWO (2) WEEKS , has your child ... | | | | | |
| XI. | 20. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | | | |
| | 21. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | | | |
| | 22. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | | | |
| | 23. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | | | |
| XII. | 24. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | | | |
| | 25. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | | | |

DSM-5-TR Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____

Age: _____

Date: _____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

| | | None Not at all | Slight Rare, less than a day or two | Mild Several days | Moderate More than half the days | Severe Nearly every day | Highest Domain Score (clinician) |
|-------|-----|--|--|-------------------------|--|----------------------------------|---|
| | | During the past TWO (2) WEEKS , how much (or how often) have you... | | | | | |
| I. | 1. | Been bothered by stomachaches, headaches, or other aches and pains? | | | | | |
| | 2. | Worried about your health or about getting sick? | | | | | |
| II. | 3. | Been bothered by not being able to fall asleep or stay asleep, or by waking up too early? | | | | | |
| III. | 4. | Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game? | | | | | |
| IV. | 5. | Had less fun doing things than you used to? | | | | | |
| | 6. | Felt sad or depressed for several hours? | | | | | |
| V. & | 7. | Felt more irritated or easily annoyed than usual? | | | | | |
| VI. | 8. | Felt angry or lost your temper? | | | | | |
| VII. | 9. | Started lots more projects than usual or done more risky things than usual? | | | | | |
| | 10. | Slept less than usual but still had a lot of energy? | | | | | |
| VIII. | 11. | Felt nervous, anxious, or scared? | | | | | |
| | 12. | Not been able to stop worrying? | | | | | |
| | 13. | Not been able to do things you wanted to or should have done, because they made you feel nervous? | | | | | |
| IX. | 14. | Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you? | | | | | |
| | 15. | Had visions when you were completely awake—that is, seen something or someone that no one else could see? | | | | | |
| X. | 16. | Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else? | | | | | |
| | 17. | Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off? | | | | | |
| | 18. | Worried a lot about things you touched being dirty or having germs or being poisoned? | | | | | |
| | 19. | Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening? | | | | | |
| | | In the past TWO (2) WEEKS , have you... | | | | | |
| XI. | 20. | Had an alcoholic beverage (beer, wine, liquor, etc.)? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 21. | Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 22. | Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 23. | Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| XII. | 24. | In the last 2 weeks, have you thought about killing yourself or committing suicide? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. | Have you EVER tried to kill yourself? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

DSM-5-TR Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____

Age: _____

Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past **TWO (2) WEEKS**.

| | During the past TWO (2) WEEKS , how much (or how often) have you been bothered by the following problems? | None Not at all | Slight Rare, less than a day or two | Mild Several days | Moderate More than half the days | Severe Nearly every day | Highest Domain Score (clinician) |
|-------|---|-----------------------|--|-------------------------|---|----------------------------------|---|
| I. | 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 | |
| | 2. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 | |
| | 5. Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 6. Feeling nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 | |
| | 7. Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 | |
| | 8. Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 | |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | 0 | 1 | 2 | 3 | 4 | |
| | 10. Feeling that your illnesses are not being taken seriously enough? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 11. Thoughts of actually hurting yourself? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 12. Hearing things other people couldn't hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 | |
| | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 | |
| | 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 | |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 | |
| XII. | 19. Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 | |
| | 20. Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 | |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 | |
| | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 | |
| | 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 | |

Client Name: _____ Insurance ID: _____

Telehealth Policy and Consent for Therapy Services

1. What is Telehealth?

Telehealth refers to the delivery of healthcare services, including mental health services such as therapy, through electronic communication and digital platforms. These services may include video calls, phone calls, and secure messaging. Telehealth is designed to provide convenience and accessibility to clients who are unable to attend in-person sessions.

For therapy, telehealth allows clients to engage in sessions remotely, whether from home or another secure location, using a computer, tablet, or smartphone with internet access.

The following policies and procedures must be followed in order to provide telehealth services for you and your minor child.

Before a client is seen by telehealth we first have all initial paperwork filled out and a copy of ID and insurance cards.

Insurance companies require all telehealth sessions to have an uninterrupted connection with synchronous audio and visual in order for the service to be billed to and covered by your insurance provider. To better serve you, we request that you use a secure tablet or PC with a reliable, strong internet connection. Alternatively, you may switch your phone into airplane mode and connect to a secure internet source such as a private WI-FI or personal internet hotspot.

We use [Doxyme.com](https://www.doxyme.com) for telehealth services. You will receive a link to the email address you provided at your appointment time from [Doxyme.com](https://www.doxyme.com).

Telehealth sessions cannot be performed while you are a driver or passenger in a vehicle. You must be in a confidential setting, just as you would be if you were inside the counseling office.

Telehealth sessions cannot be recorded for any purpose. A person may not record their session and put on social media. If a person records a telehealth session and broadcasts it on for example Facebook Live, it creates severe legal, privacy, and professional issues for both the person and the healthcare provider. This action is a major breach of privacy and could lead to significant legal and financial consequences.

Clients are required to sign in on time for all telehealth sessions. Clients are also required to schedule their appointments for when they can be present the entire session. If you sign in late or leave the session early, you will be asked to pay the difference in what can ethically be billed to your insurance company and the time scheduled that we cannot bill. This will be based on each insurance company's policies. We cannot bill your insurance company for time that is scheduled that you were not present.

All copayments or fees are required to be paid at least 15 minutes prior to your session so the office can let your counselor know to begin the session. The office does not call you for payments. You must call the office at least 15 minutes prior to your session, or you can put a card on file that will be run the day of your appointment. A card on file will also be used for missed appointment fees.

Client Name: _____ Insurance ID: _____

Most insurance companies require the client to be present for all telehealth sessions. This means that we cannot bill your insurance provider for telehealth sessions in which the identified client is not present. Should you request this type of session, the payment would come directly from you. Please let the administrative staff know if you have any questions.

2. Risks of Telehealth

While telehealth offers many benefits, it is important to understand that there are certain risks associated with receiving therapy through virtual platforms. These include:

- **Technology-related Issues:** Interruptions in internet connectivity, audio, or video issues that may disrupt the session.
- **Confidentiality and Security Risks:** While we use secure, HIPAA-compliant technology, there is still the risk of unauthorized access to personal health information. It is important that clients take precautions to ensure their environment is private and secure during sessions.
- **Miscommunication or misunderstandings:** Non-verbal cues may be harder to interpret in a virtual setting, which could impact the communication between the client and the therapist.
- **Emergency situations:** In the event of an emergency, the therapist may not be able to provide immediate intervention or assistance due to geographic distance or technological limitations.

3. Expectations Regarding Telehealth

To ensure the effectiveness and security of your telehealth therapy sessions, please keep the following expectations in mind:

- **Environment:** Choose a quiet, private location for your telehealth session. This will help minimize distractions and ensure confidentiality. Ensure that your device is fully charged or plugged in for the session. Telehealth sessions cannot be performed while you are a driver or a passenger in a vehicle. You must be in a confidential setting, just as you would be if you were inside the counseling office.
- **Technology Requirements:** You are responsible for ensuring you have the necessary technology to participate in telehealth services. This includes access to a device with a camera and microphone, a stable internet connection, and any required software (e.g., Zoom, Doxy.me, etc.). We will provide instructions on how to use the telehealth platform before your first session.
- **Punctuality:** Just as with in-person sessions, it is important to be on time for your telehealth appointment. If you are running late, please notify us as soon as possible.
- **Communication:** If you experience technical difficulties during your session, please reach out to your therapist immediately via the contact number or email provided. We will do our best to resolve the issue promptly or reschedule the session if needed.

Client Name: _____ Insurance ID: _____

- **Payments:** all copays or fees are required to be paid at least 15 minutes prior to your session so that we can let your counselor know to begin the session. You can put a card on file that will be run the day of your appointment. A card on file will also be used for missed appointment fees.

4. Emergency Protocols

While telehealth is an effective tool for therapy, it is not suitable for emergency situations. If an emergency arises during a session, or if the therapist is concerned about your safety, the following protocols will apply:

- **Crisis Situations:** If you are experiencing a mental health crisis, please call 911 or go to your nearest emergency room immediately. If you are at risk of harming yourself or others, it is critical that you seek immediate in-person assistance.
- **Therapist's Location:** In the event of an emergency, your therapist may not be able to physically intervene or reach you quickly. You will be asked to provide emergency contact information, including a local contact person (such as a family member or friend), to ensure your safety in the event of a crisis.
- **Local Resources:** Your therapist will provide you with contact information for local emergency services, crisis hotlines, and mental health resources for your area. It is important to be aware of these resources and how to access them in case of an emergency.
- **Inability to Connect:** If there is a disruption in the telehealth session and we are unable to reconnect within a reasonable timeframe, the therapist will contact you via the phone number or email provided to discuss the situation.

5. Consent to Telehealth Services

By signing below, you consent to receive therapy services via telehealth. You understand the potential risks involved and agree to the following:

- You have been informed of the risks and benefits of telehealth and have had the opportunity to ask questions.
- You agree to adhere to the expectations outlined in this document to ensure the effectiveness and security of your therapy sessions.
- You understand that telehealth is not appropriate for emergency situations, and you will seek emergency care if needed.
- You give consent for your therapist to communicate with you using the technology platform specified for telehealth services.
- You acknowledge that you will inform your therapist of any changes to your contact information or emergency contacts.

Client Name: _____ Insurance ID: _____

Emergency Information

1. Name: _____
2. Emergency Contact: _____
3. Closest hospital: _____
4. Closest fire department: _____
5. Closest police department: _____

Acknowledgment of Telehealth Policy and Consent

I, the undersigned, have read and understood the above Telehealth Policy and Consent. I agree to receive therapy services via telehealth under the terms outlined in this document.

Client Name (Printed): _____

Client Signature: _____ Date: _____

Therapist Name (Printed): _____

Therapist Signature: _____ Date: _____