Client Information and Consent to Treatment/Evaluation

Phoenix Therapeutic
Robin Lipsker, MSW, LICSW, CDP, MAC
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Phoenix ID# (Office use only) _________

Name ____________________________ ______________________________________ _____
Last First MI

Street Address_______________________ City____________________________ State____ Zip________

Mailing Address______________________ City____________________________ State____ Zip________

Social Security Number _________-_____-_______ Gender? F M Other

Telephone *Home* _____________________*Work* ____________________*Mobile*_____________________

Other ____________________ Email ____

Birth Date ______________Age ______________Childhood Nicknames ___________________________

Where can I leave messages?____

Emergency Contact Phone_______________________ Relationship to client_______________________

Primary Insurance Company _________________ Policy #______________Group #_________________
Primary Insured (name)_____________________________
Secondary Insurance Company ________________ Policy #_____________Group #_________________
Name of and address of Person Responsible for payment of services if other than above:
____

Is your condition related to:

Employment □ Yes □ No

Auto Accident □ Yes □ No

Other Accident □ Yes □ No

Education / Training (Highest Level or Grade Attained)____

Military Service □ Yes □ No Dates ______________Did you serve in combat? □ Yes □ No

Sexual Orientation □ Heterosexual □ Gay/Lesbian □ Bisexual
Relationship Status □ Married □ Never Married □ Widowed □ Single
□ Divorced □ Separated □ Living together as partners
Spouse / Partner's Name ______________________________________ Age________________________

If married, duration of present marriage _______________Are there children living at home? □ Yes □ No

Previous Marriages (Date / How ended) ____

Previous Marriages (Date / How ended) ____

Names and ages of children Age___________ Age_____________
Age___________ Age____________
Have you had previous therapy? □ Yes □ No Spiritual or Pastoral Counseling? □ Yes □ No

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When? ___________________ With whom?_____________________________________

Are you presently seeing a therapist? □ Yes □ No If yes, whom?____________________________________

How did you hear about me?

□ Clergy Person □ Social Service Agency □ Family
□ Friend □ Employer □ Advertisement (where?)________________
□ School □ Former Clients □ PCP recommendation? □ PCP referral
Please include specific name if appropriate____

Your Physician's Name ____
Date of last medical exam________________________
Are you currently on medication? □ Yes □ No
If so, which medication(s)?__________________________
Prescribed by ____________________
Major surgeries in the past five years? □ Yes □ No
For which condition(s)? __________________________
Other health related conditions__________________________
What is your current physical condition? □ Poor □ Fair □ Average □ Good □ Excellent
What is your current emotional condition? □ Poor □ Fair □ Average □ Good □ Excellent
Which of the following describe or relate to the concerns that bring you here?
Relationship with: __________________________
Loss of: __________________________

□ Aging Issues □ Mid-Life Issues
□ Anger □ Suicidal Feelings □ Partner □ Self-Respect
□ Anxiety □ Religious Doubts □ Parents □ Identity
□ Frequent Crying □ Legal Issues □ Children □ Faith
□ Eating / Food □ Finances □ Others □ Meaning
□ Alcohol / Drugs □ Vocation/Career □ Love □ Loneliness
□ Physical Health □ Self Doubt □ Self Esteem □ Abuse Issues
□ Life Transition □ Poor Appetite □ Sexual □ Guilt
□ Self Loathing □ Physical □ Sexual Concerns □ Sleep Disturbances
□ Emotional □ Fear □ Hopelessness □ Verbal
□ Grief □ Weight Loss

Please make an "X" next to all the Alternative Treatments you have tried for your condition(s)?

□ None □ Colonics □ Nutritional Therapy □ Environmental medicine
□ Naturopathic medicine □ Massage □ Yoga □ Homeopathy
□ Acupuncture □ IV (chelation) therapy □ Hypnosis □ Light therapy
□ Chiropractic □ Rolfing □ Biological Dentistry □ Meditation
□ Iridology □ Reiki □ Ayurveda □ Other:

State in your own words the concerns that bring you to therapy:___________________________________

____

How will you know when your current concerns are resolved?

____

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly*
- *Obtain Payment form third party payers*
- *Conduct normal healthcare operations such as quality assessments*

Acknowledgement of Notice of Privacy Practice I have been informed by Phoenix Therapeutic and Consulting Services of our Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Phoenix Therapeutic and Consulting Services to obtain a current copy of this notice.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand Phoenix Therapeutic and Consulting Services is not required to agree to my requested restrictions, but if Phoenix Therapeutic and Consulting Services does agree, then they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Phoenix Therapeutic and Consulting Services has taken action relying on this consent.

Check all that apply to this consent:
□ Please do not phone me at home. Use this alternate phone number: ___________________________
□ Please do not phone me at work. Use this alternate phone number: ____________________________
□ Please do not leave messages on my answering machine.
□ Please do not contact me by e-mail.
□ Please send me mail, including my bills, to this alternate address: ______________________________
□ Other request: (please describe)____

CONSENT FOR TREATMENT/CARE

I consent to treatment and care by Phoenix Therapeutic health care providers. I am aware that the psychotherapeutic practice of clinical Social Work is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

AUTHORIZATION TO RELEASE INFORMATION:

I have read and I accept this policy for my testing and/or treatment with Phoenix Therapeutic and Consulting Services. In obtaining payment for services, I authorize my healthcare provider to furnish information from my medical records to any company that may be responsible for payment for all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim. I understand that Phoenix Therapeutic has the right to bill for missed and late-cancelled appointments.

FINANCIAL RESPONSIBILITY

I understand and agree that charges for professional services performed by a clinical Social Worker may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts, I agree that the overpayment may be applied to pay any outstanding charges on any of my Phoenix Therapeutic accounts.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

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I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to Phoenix Therapeutic on my behalf. I authorize Phoenix Therapeutic to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to Phoenix Therapeutic.

Social Security Number

I have given my social security number voluntarily. Phoenix Therapeutic may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

I have read the above information and fully understand my obligations and relationship with Phoenix Therapeutic and Consulting Services

________________________________ ________________________________

Signature *Date*

____

Print Name

Disclosure Statement

Phoenix Therapeutic

Robin Lipsker, MSW, LICSW, CDP, CADC II
PHONE: 360-827-1666 **FAX**: 440-398-1287
robin@phoenixtherapeutic.net

I am a Licensed Clinical Social Worker, and abide by the ethical standards of the National Association of Social Workers. This document contains important information about my qualifications, methods, business policies, and the mutual expectations of our professional relationship. Please read it carefully and jot down any questions you have so we can discuss them. Once you sign this, it will constitute a binding agreement between us.

Credentials, Experience, and Methods

I am a Washington Licensed Independent Clinical Social Worker (Lic. # LW60330022), holding a Master's Degree in Social Work (MSW) from the University of Denver and a Bachelor's degree in Social Welfare from the University of Washington. Additionally, I am a Washington state Licensed Chemical Dependency Professional (CDP Lic. # CP00005119) and an Oregon Certified Alcohol/Drug Counselor II (CADC II).

As a licensed counselor all your sessions with me are strictly confidential. My professional memberships include the National Association of Social Workers (NASW). I adhere to the NASW Code of Ethics as well as the Ethical Standards of the NASW. These standards are available to you from www.socialworkers.org/pubs/code/code.asp.Also, for teletherapy, I adhere to the NASW technology standards found at http://www.socialworkers.org/practice/standards/naswtechnologystandards.pdf. These ethics and standards are intended to protect the welfare of my clients and the community I serve.

I am both trained and experienced in the areas of anxiety, depression, complex trauma, Post Traumatic Stress Disorder (PTSD), loss & grief, chronic pain, life transitions, relationships, and sexuality issues. I work with adult individuals, adolescents, couples, and groups. I employ solution-focused, narrative, and several body-centered, mindfulness-based psychotherapies, including Motivational Interviewing and Cognitive Behavioral Therapy CBT). I have an in depth understanding of the dynamics of dysfunctional family systems resulting from chemical dependency, mental illness, domestic violence, veteran's issues, and workplace bullying. Each of these methods respects the client as the best authority on his or her healing process and operates on the premise that the body-mind is always moving toward healing.

Therapy is a joint effort that is successful with your hard work, energy, and courage. It provides a safe place to explore reactions, thoughts, and feelings about yourself and your life and to explore how past experiences have shaped the ways you view yourself and the world around

you. The ensuing self understanding and self-acceptance supports you in shedding old ways and developing new ways of responding to life. It can have benefits and risks. Since it may involve exploring unpleasant aspects of your life or yourself, you may temporarily experience increased discomfort, such as anxiety, sadness, guilt, anger, or frustration. During the process of change, relationships may become strained. However, as you experience yourself more deeply and engage in life more authentically, there is often a sense of relief and spaciousness even if difficult emotions are present. Psychotherapy can lead to improved self-awareness and self-acceptance, improved coping skills, increased effectiveness in life, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees about what you will experience.

After our first few sessions, I will initiate a discussion about your satisfaction thus far with our work. I do this because therapeutic success depends in part on the degree to which you feel safe, accurately seen, and collaboratively engaged with. This discussion gives you an opportunity to clarify what is working and what is not, and it gives me an opportunity to understand your needs better and to adjust my approach if needed. As therapy involves a large commitment of time, money, and energy, these check-ins help us work as efficiently as possible. If at any time you feel an ongoing sense of dissatisfaction with our work that we don't seem to be able to remedy together, I will be happy to give you the names of other mental health professionals whose work I respect.

Business Policies

Sessions range from 50 to 120 minutes and occur at various frequencies. Decisions about length and frequency of sessions and duration of care are guided by my professional judgment and your wisdom about your needs, financial and time constraints.

My hourly fee for individual counseling is $150.00. My fee for a mental health diagnostic interview is $250.00. Washington Health Professionals Services (W.H.P.S.) peer support group fee is $20.00 per session. Sliding fee scales are sometimes available. I require 24 hour notice for cancelled appointments, and I reserve the right to bill for late-cancelled and no-shows, as I am not able to bill insurance for a late cancelled or missed appointment.

My fees for non-therapy services are as follows:
Preparation time (including submission of records): $220/hr
Phone calls: $220/hr
Depositions: $250/hour
Time required in giving testimony: $250/hour
Mileage: $0.40/mile
Time away from office due to depositions or testimony: $220/hour
All attorney fees and costs incurred by the therapist as a result of the legal action.
Filing a document with the court: $100
The minimum charge for a court appearance: $1500

Outside-of-session services (telephone conversations with you or with other professionals on your behalf, report writing, records or treatment summary prep; attendance at meetings or consultations regarding your care) in excess of 15 minutes once per month are charged at my prorated hourly fee. I do not typically get involved in court cases, custody disputes, or mediation. If I am called by a judge or an attorney to testify in a case in which you are involved, payment from you is due prior to any services rendered at a fee of $200.00 an hour.

When I am unavailable, my telephone is answered by a confidential answering machine that I monitor frequently. I make every effort to return calls within 24 hours, with the exception of weekends, holidays, and when I am out of town. If you are in crisis and need a call back immediately, please leave me a message stating as such and also call 911 or a helpline at 211 or go to the nearest Emergency Department. I will provide a backup therapist's name or my cell phone number as needed when I am out of town.

Confidentiality

Discussions between you and me, and even the fact that you are in therapy with me, are confidential. For this reason, if I see you in public, I will protect your confidentiality by greeting you only if you greet me first and following your lead in our interaction. If we do greet, I will not disclose how I know you.

All information shared will be kept confidential with the following exceptions:

a) You give written permission to disclose information.

b) I am providing the required information to my biller and your insurance company for insurance billing purposes, if applicable.

c) I believe you are an imminent danger to yourself or another.

d) I learn that you are involved in or knowledgeable about the abuse, neglect, or exploitation of a child, elderly person, or disabled person.

e) When I consult with colleagues to enhance my work with you, such consultation is done in a confidential setting and with identifying information about you omitted.

f) I am ordered by a court to disclose information.

g) You bring accusations of misconduct or a negligence suit against me.

Mutual Expectations

As a client you have the right to:

• Freedom from discrimination on the basis of race, color, religion, gender, national origin, handicap, or other unlawful category while seeking and receiving services.

• A safe, healing environment in which you feel clearly seen, compassionately supported, and wisely guided.

• A collaborative relationship with me in which you are recognized as the primary expert about your life and in which you actively participate in and are fully informed about our work together.

• Freely discuss any questions, discomforts, or concerns you have during our sessions.

• Discontinue our work together at any time and for any reason, though this decision is most fruitful for you if done in relationship with me.

• Confidentiality in the therapeutic relationship as described below.

• Understand my credentials, methods, and business policies as outlined in this document.

• Submit complaints to the Washington State Department of Health, Health Systems Quality Assurance, Complaint Intake, P.O. Box 47857 Olympia, WA 98504-7857 or the Oregon Board of Licensed Social Workers at oregon.blsw@state.or.us or 503-378-5735

As a client, you have the responsibility to:

• Actively participate in and be fully informed about our work together, including the contents of this document.

• Discuss plans to discontinue therapy with me before doing so.

• Keep appointments or cancel at least 24 hours in advance or pay for a missed session. Missed sessions are usually not payable by insurance and must be paid by you at $130/hr. or our agreed upon hourly fee.

• Pay at time of service our agreed upon hourly fee (if cash-pay), or your co-pay and/or co-insurance, plus the difference between your insurance's allowed amount and the billed amount, unless otherwise negotiated by us or prohibited by insurance contract (if using insurance).

• Inform me of changes in address or telephone number or of changes in financial status that would affect your ability to pay.

• Inform me if you are seeing another mental health professional so collaborative treatment can be provided.

• Inform me if you are taking psychotropic medications or using other mind-altering substances during the course of our work together.

I have read the above information and understand the terms of this agreement. I seek and consent to the psychotherapeutic services of Phoenix Therapeutics.

Signature of client or personal representative ______________________

Date _________________________

Printed name of client or representative ____________________________

Relationship to client __________________________

Description of representative's authority________________________________

□ Copy requested & provided to client/parent/personal representative

Phoenix Therapeutic
Robin Lipsker, MSW, LICSW, CDP, CADC II
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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:

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

Your Rights

Notice of Privacy Practices

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 not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us express written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

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

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

Effective date: January 1, 2016
For more information or questions, contact Robin Lipsker robin@phoenixtherapeutic.net 360-827-1666
We never market or sell personal information.

Phoenix Therapeutic

Robin Lipsker, MSW, LICSW, CDP, CADC II

PHONE: 360-827-1666 **FAX**: 440-398-1287

robin@phoenixtherapeutic.net

(1) Individual Information:

Print Name of Patient	**Birth Date**	**Patient ID #**

(2) Information may be disclosed by:

____

Name of Physician, provider or organization releasing information

____

Street Address, City, State, Zip

____

(3) Information may be disclosed to

____

Name of organization or person to receive information

____

Street Address, City, State, Zip (**you MUST supply an address**)

_(_____)___________________ _(_____)______________________________

Daytime Phone Fax

(4) What kind of Information do you want disclosed? (check ONE box, copy fees may apply)

- ☐ Information from the most recent 2 years of visits
- ☐ Information from date ___/____/____ to _____/______/____(YOU MUST SPECIFY DATES)
- ☐ Specific Information (Please specify) ____
____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- ☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g)).
- ☐ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).

(5) Why are you asking for this health information to be released? (Check ONE box)

☐ Attorney ☐Insurance ☐Doctor ☐Medical Leave

☐Personal ☐Other (Specify)____

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _______________________(insert applicable date or event). If no date is indicated, the Authorization will expire 90 days after the date of my signing this form.

You may also authorize the release of information for treatment provided after the date of the signature on this Authorization as long as such treatment occurs while this authorization has not expired. Please initial if you would like this Authorization to release information about healthcare you receive after the date of your signature. _______________
(Initial here)

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NOTICE
Physicians and other DOH licensed healthcare providers are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS
This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Phoenix Therapeutic, 1673 South Market Blvd # 140, Chehalis, WA 98532

The revocation will take effect when Phoenix Therapeutic receives it, except to the extent Phoenix Therapeutic or others have already relied on it. Revocation will not affect any actions already taken by Phoenix Therapeutic based upon this Authorization.

You are entitled to receive a copy of this Authorization.

________________________________ ______________________________________
Print Name Signature (Patient, Parent, Representative)

____/_____/______ ____________ ______________________________________
Date Time Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

__________________________________ ______________________________________
Minor Signature Witness (only if patient unable to sign) or Interpreter
(Signature of minor is also required if minor is age 13-17)

Beck Anxiety Inventory

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

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

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

Interpretation

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

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

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

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

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

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

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

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

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

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

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

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

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

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

11.

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

12.

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

13.

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

14.

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

15.

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

16.

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

17.

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

18.

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

19.

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

20.

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

21.

0	I have not noticed any recent change in my interest in sex.
1	I am less interested in sex than I used to be.
2	I have almost no interest in sex.
3	I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression