BENISON
COUNSELING CENTER

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CONSENT TO RECEIVE COUNSELING SERVICES

HIPAA: The Health Insurance Portability and Accountability Act (HIPAA) provides clients with several new or expanded rights with regard to your clinical record and disclosures of protected health information. Signing below indicates that you understand the "Notice of Privacy Practices" which explains the policies used and your rights related to your protected health information, and that you agree to the terms it delineates during our professional relationship.

Nature of treatment: Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements cannot be guaranteed for any condition due to the many variables that affect therapy. Experiencing uncomfortable feelings, discussing unpleasant situations and aspects of your life, changing thoughts, feelings, and behaviors may be painful and challenging at times and are considered risks of therapy sessions. Interventions depends on many factors, such as the nature of your difficulties and readiness for change.

Approach: Your therapist will complete an intake session to understand how your current difficulties may have developed and are maintained within the various contexts of your life. A treatment plan will be developed including some potential goals for therapy, and the strategies that may be used to help you reach your goals. Throughout the therapy you are invited to share any concerns or questions that you may have about the therapy process. Services are by appointment only; in an emergency please call 911 or go to the emergency room.

Fees and payment: Sessions are approximately 45-50 minutes in length, sessions are to end no later than 5-minutes to the hour. If time is exceeded, there may be additional cost billed to you or your insurance. Every attempt is made to see clients on time. To work towards this goal, payment is due at least 24 hours prior to your session. TWENTY-FOUR (24) hours' notice is required to CANCEL OR RESECHEDULE an appointment to avoid being billed for the full fee of the missed session. THE ONLY EXCEPTIONS ARE UNEXPECTED ILLNESS OR EMERGENCIES.

Limits of Confidentiality: Counseling records may include items such as personal information, progress notes, and evaluations, and will be shredded 7 years after your file has been closed. No information about you can be released to a third party without your prior written consent, or verbal consent in the case of an emergency. Exceptions include: (1) risk of imminent danger, such as suicide, death, risk of a child running away, or serious bodily harm to an identifiable person or group, (2) suspected or known abuse or neglect of a child or older adult, (3) unsafe operation of a motor vehicle, (4) requests ordered by a court of law, or (5) access is requested by your insurance provider or other third-party payers are given information that they request regarding services to the clients. Disclosure of identifying information will be minimized, and names will not be released without consent.

Mutual rights and responsibilities: The relationship must remain limited to a respectful therapeutic framework. You may refuse any therapeutic suggestions offered to you, or to suspend or cease treatment at any time without penalty. If you decide to stop treatment for any reason, please notify your therapist so that your file can be closed and/or you can be referred to another resource. If you stop treatment without an explanation, your file will automatically be closed after 30 days.

Consent to treatment: I have read and understood the above information, and any questions that I had have been answered. I understand and agree with the above consent form, and freely consent to receive counseling s ervices.

Name of client: _____ Signature: _____ Date: _____

Counseling Intake Form

Full Name _____ E-mail _____ Cell/Home Phone _____

Ethnic Background _____ Gender _____ Date of Birth _____

Address City/State/Zip _____ Emergency Contact Name/Phone _____

Occupation _____ Employer/School _____ Highest level of Education _____

Spouse/Partner's Name _____ Spouse/Partner's Occupation _____ Spouse/Partner's Phone Number _____

Ethnic Background _____ Gender _____ Date of Birth _____

Relationship Status _____ Length of Relationship _____ Living Together? _____

How would you describe the quality of your Current Relationship? _____

Do you have children? YES NO List name and age: _____

Have you been to therapy before? YES NO When\Reason: _____

What outcome/diagnosis was given? _____

Are you on medication? YES NO Name/Dosage: _____

Please briefly describe the concern(s) that brings you to therapy: _____

Presenting Issues (Rank 1-5 with 1 being of most concern):

Please elaborate on any areas of concern in space provided.

_____ Self-esteem, self-confidence
_____ Anxiety, nervousness, fears
_____ Depression
_____ Sexual concerns
_____ Angry, hostile feelings
_____ Traumatic experiences
_____ Physical distress
_____ Eating or appetite problems
_____ Alcohol or drug problems
_____ Sleep problems
_____ Parent-child problems
_____ Spiritual/Existential issues

_____ Family conflicts or pressures
_____ Friendship conflicts
_____ Relationship/marital concerns
_____ Shyness, being assertive
_____ Loneliness
_____ Procrastination or motivation
_____ Gay/Lesbian issues
_____ Suicidal feelings or behaviors
_____ Stress
_____ Self-control
_____ Health problems
_____ Work or career concerns

_____ Other
_____
_____
_____
_____
_____
_____
_____

Client Name:_____ Client Signature:_____ Date:_____

Parent/Guardian Signature (if under 18)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

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

10. If you checked off *any problems,* 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?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety