Counseling Intake Procedure Checklist

Passway Counseling (PWC) is appreciative that you have decided to join us in our counseling services. Please follow this Checklist carefully to assist you in the counseling intake process by first reading the forms thoroughly. Please notice that multiple family members can register using one form with the exception of the inventories. Copy all the forms and items listed on this checklist, and completely fill them out. Then when the copies are completed scan them into a PDF* and email to PWC at drstevenwhite@passwaycounseling.com. Apps in your smartphone like TurboScan are very useful in this process and permit you to scan and send the required information with a smartphone.

Colorado state law says you must give informed consent to be treated. Therefore, all attendees to counseling sessions that are 15 years of age or older must read and sign the intake forms thus stating you received and understand this information. There are also other information items listed here not found online that are required to complete your registration into the PWC counseling program.

1. Complete all information on the Intake Sheet and sign. There is a place for different family members on the same Intake Sheet. Page 2
2. Carefully read and sign the Disclosure Statement. Page 4
3. Read all the Assignment of Benefits Form and sign. Page 7
4. Complete the Credit Card Authorization Form and the owner is to sign. A credit card on file is required of all PWC clients, including both self-pay and medical insurance clients. Page 8
5. Read and sign the Notice of Privacy Rights. Page 9
6. Each individual attendee is to complete both the SCL-90 and the Zung inventories. Pages 12-16
7. Joining the therapist online for counseling requires your completion of the Telebehavioral Health (TBH) Consent Form and signature. Click on the TBH consent form site. Page 17-18
8. In addition to the website forms include copies of the front and back of the following three items even if you plan to use your Employee Assistance Program (EAP):
   - Official I.D.
   - Your credit Card
   - Medical Insurance Card

   Also, if you do plan to use an EAP, include the name of the managing company and your case number.
9. Though we are attempting to go paperless in our registration, any hard copies given to the PWC counseling program must be one sided for filing purposes.

Thank you and welcome aboard,

Passway Counseling Staff

* Please DO email all documents IN ONLY ONE TO THREE SCANS IN ONLY ONE EMAIL if possible. Please DO NOT SEND JPEGs OR PHOTOGRAPHS, ONLY SCANS.

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CLIENT INTAKE SHEET

NAME ____DATE ____________________

MAILING ADDRESS: Street ____

City ______________________________State ______________Zip Code __________________

MARITAL STATUS (circle one): Married Separated Divorced Single

MARITAL HISTORY: Date(s) of Marriage(s):________________ ________________ ____________________
Date(s) of Divorce(s):_________________ ________________ ____________________

PHONE: Home ____________________Work_________________________ Cell______________________

DATE OF BIRTH: _______________ Age_____ Email____

Race (optional): ________________________ Nationality/Ethnicity (optional): ______________________________

REFERRED BY: ____

NAME OF SPOUSE: ____
MAILING ADDRESS, if different from above: Street____
City____________________________State____ZipCode__________

MARITAL HISTORY: Date(s) of Marriage(s):________________ ________________ ____________________
Date(s) of Divorce(s):_________________ ________________ ____________________

PHONE: Home____________________ Work_________________________ Cell______________________
DATE OF BIRTH: ________________ Age_____ Email____
Race (optional): ________________________ Nationality/Ethnicity (optional): ______________________________

OTHER HOUSEHOLD MEMBERS:

Name	DOB	Relationship	Name	DOB	Relationship
1.			3.		
2.			4.		

Do you have custody of any child(ren)? YES NO If YES, please indicate relationship:__________________________

PRESENTING PROBLEM (Brief description): ____
____

PRIOR THERAPY/COUNSELING (Indicate with whom and when: ____
____

LEGAL INVOLVEMENT: YES ___ NO ________ (Attorneys, GALs, Courts, etc.) IF YES, PLEASE LIST:

Name: ____ Phone #:_____________________________

SESSION FEE: ____________________________ ANNUAL HOUSEHOLD INCOME: $__________________

INSURANCE: Present Insurance Card to be copied for your file

Name of Insurance Carrier:____

Insurance ID#:_________________________________Insured Client's Date of Birth:________________________

Name of 2nd Party Billing, if applicable:____Amount: $__________

____

Client Signature

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DISCLOSURE STATEMENT

Professional Ethics and Colorado State Law require that the following information be disclosed to each client at the initial therapy session.

1. THERAPIST INFORMATION:

Name: R. Steven White, EdD
Address: PassWay Counseling
Email: drstevenwhite@passwaycounseling.com

Phone #: 303-376-9066

2. THERAPIST CREDENTIALS:

License: License No. #073, Licensed Marriage and Family Therapist in Colorado
Degrees: Doctorate and Master in Counseling Psychology, Texas A&M - Commerce with Doctoral Dissertation in Marital Satisfaction;
Bachelor in Bible and Christian Education, Abilene Christian University
Professional Experience: Over 35 years of experience in providing psychotherapy to individuals, couples, children, and families
Professional Associations: Certified Clinical Fellow with American Association for Marriage and Family Therapy; was Certified Sex Therapist and Sex Educator with American Association of Sex Educators, Counselors, and Therapists

3. REGULATIONS FOR PSYCHOTHERAPISTS: C.R.S. § 12-43-214.1c The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Department of Regulatory Agencies. Questions or complaints may be addressed to: Department of Regulatory Agencies, 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7766.

4. CLIENT RIGHTS AND IMPORTANT INFORMATION:

a. You are entitled to receive information from PassWay Counseling (PWC) about methods of therapy, the techniques used, and the duration of your therapy. Please ask if you would like to receive this information.
b. The PWC standard therapy fee is $135.00 per 50 minute hour for counseling. Please plan to have your I.D., insurance card, and a credit card on file with PWC. Please copy back and front of these items and include when you PDF your intake forms to PWC.
c. You can seek a second opinion from another therapist or terminate therapy at any time.
d. In a professional relationship (such as client and therapist), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies.
e. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) therapists are required to report any suspected incident of child abuse or neglect to law enforcement; (2) therapists are required to report abuse, caretaker neglect, and/or exploitation of an at-risk elder (age 70 and older) to law enforcement within 24 hour of observation or discovery; (3) therapists are required to report any threat of imminent physical harm by a client to law enforcement and to the persons(s) threatened; (4) therapists are required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (5) therapists are required to report any suspected threat to national security to federal officials; and (6) therapists may be required to disclose treatment information when ordered by a court. Military tribunals, applying the Uniform Code of Military Justice, do not recognize the same privileges that Colorado law recognizes. Therefore, active duty military clients give informed consent by signing this Disclosure Statement that treatment records may be subpoenaed and subject to disclosure pursuant to a court order enforcing the subpoena.
f. In order to keep the relationship professional, please do not give your therapist any gifts, however small.
g. If you request treatment records from PWC, the therapist may provide a treatment summary in compliance with Colorado law C.R.S. § 25-1-802 and the HIPAA Privacy Rule. By signing this Disclosure Statement, you agree with this practice.
h. If you are involved in a divorce or custody litigation, you need to understand that the therapist's role is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this Disclosure Statement, you agree not to call the therapist as a witness in any such litigation. Experience has shown that testimony by therapists in domestic cases causes damage to the clinical relationship between a therapist and client. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

i. A divorced parent bringing his or her child(ren) for treatment must provide to the therapist the divorce decree or an order entered by the court stating that the parent has decision-making authority. Pursuant to C.R.S. § 14-10-124, courts are empowered to allocate parental responsibilities when a divorce is granted. Those parental responsibilities include decisions concerning the child(ren)'s treatment providers. Where joint decision-making authority has been granted to both parents, then both parents must consent to treatment by signing a therapist's Disclosure Statement. Both parents of the child(ren) will be entitled to receive treatment information and will be involved in the treatment process, which is generally in the best interests of the child(ren).
j. When parents are divorced, Colorado law allows any parent who has been assigned parental responsibilities access to medical records. Therefore, in compliance with C.R.S. §14-10-123.8, you authorize the therapist to provide access to treatment information to such an individual by authorizing the therapist to provide services to a child in your custody.
k. In treating an adolescent who is 15 years of age or older, the person giving informed consent for treatment and the adolescent agree that the therapist will determine what information, in his/her professional judgment, is appropriate to be shared with the parents or guardians concerning treatment issues and what information, in the discretion of the therapist, will remain confidential between the adolescent and the therapist.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado Statutes (see Section 12-43-218, C.R.S. in particular and the Notice of Privacy Rights). You should be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding.

5. BILLING INFORMATION:
   a. The standard fee per 50 minute session is $135.00.
   b. Each client hereby agrees to a fee of $135.00 per session, if not choosing to use insurance.
   c. Payment is expected at the end of each session. All justifiable fees not covered by insurance are the responsibility of the client.
   d. The client is required to give at least 24 hours notice of cancellation. If 24 hours notice is not given, the client is responsible for paying $100.00 for the missed session.
   e. If the client chooses to use their insurance, the client is responsible for all co-pays and deductibles. The client is to provide a copy of their insurance card (back and front) within the intake form PDF. The client agrees to have a credit card on file with PWC to pay justifiable service fees and account balances.

6. COUNSELING AGREEMENT:
   a. The client grants permission for any therapy, audio/video taping, or diagnostic evaluation that may be deemed pertinent in counseling, including the client, spouse, or family. The therapy sessions, records, and tapes are strictly confidential, except where State Law requires the reporting of threats of violence, harm, or child abuse and neglect (from evidence or suspicion), and when information is subpoenaed by the courts.
   b. The client understands that the information provided during therapy may only be accessed/shared with those contracted by or employees of PWC needed to provide your service. PWC will maintain strict confidentiality of this information.
   c. The client agrees to fully invest themselves in the counseling process and understands that PWC does not guarantee any particular outcome from the therapy process.
   d. The client should cancel a session only when absolutely necessary. When the client must cancel a session, they must do so at least 24 hours in advance of their scheduled appointment, know that failure to do so will result in being billed $100.00 for the missed session.
   e. The client is aware that PWC is not an emergency service. In case of an emergency, call 911 or go to the emergency department of the nearest hospital.
   f. The client agrees to discuss the termination of therapy with the therapist before discontinuing therapy.
   g. The client understands that after two consecutive session cancellations, their standing appointment time may be lost.
   h. Sessions last approximately fifty minutes. If the client shows up late for a session, the session will not be extended to compensate for the client being late.
   i. The client understands that they may not leave children unattended in the waiting room during their session. As a courtesy to all clients, please keep the waiting area quiet and orderly.
   j. The client grants permission for the employees of PWC to communicate with him/her through email, and other indicated modes.

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I/We (Print Name(s)) ____
have read the preceding information, understand my/our rights as a patient(s), and consent to treatment under these conditions.

Client Signature: ______________________________ Date: ____________________
(Parent or guardian for a minor)

Client Signature: ______________________________ Date: ____________________
(Parent or guardian for a minor)

Therapist Signature: ______________________________ Date: ____________________

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Assignment of Benefits Form
Dr. Steven White, Therapist

I, ____ , (print name) hereby authorize benefits to be assigned to PassWay Counseling (PWC) for therapy services provided to me by PWC. I hereby certify that the insurance information that I have provided to PWC is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the claim and that I am responsible for any and all amounts not payable by my insurance company, including any portion paid and not applied to in network benefits for any out of network services.

I hereby authorize PWC to submit claims on my behalf to the insurance company listed on the back and front copy of the current insurance card I have provided to PWC in good faith.

I hereby authorize and direct my insurance company to issue payment directly to PWC. I agree and understand that any funds I receive from my insurance company due for services rendered by PWC will be immediately signed over and sent directly to PWC.

I hereby authorize PWC to furnish and/or release any information necessary to insurance carriers concerning my therapy (including Highly Confidential Information as defined in the Notice of Privacy Practices) to process my insurance claim acquired in the course of my treatment and to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.

I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of services. I also understand that I am responsible for any balance due after payment by my insurance company.

I understand that PWC will bill my insurance carrier for services rendered upon verification of coverage by my insurance company. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for services rendered. If my insurance company does not remit payment within 60 days, I understand that I will be responsible for the balance due in full.

I/We (Print Name(s)) ____
have read the preceding information, understand my/our rights as a patient(s), and consent to these conditions.

Client Signature: ________________________________ Date: ____________________
(Parent or guardian for a minor)

Client Signature: ________________________________ Date: ____________________
(Parent or guardian for a minor)

Therapist Signature: ______________________________ Date: ____________________

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ONGOING CREDIT CARD AUTHORIZATION FORM

DATE:______________________________________

I, ____, authorize **PassWay Counseling (PWC)** to

charge my credit card as stated:

My signature below indicates my knowledge and acceptance that my credit card, listed below, is to be charged on an ongoing basis to pay copays, or fee balances on account**, for me or my family,** to **PWC** that insurance does not cover. I also acknowledge that this authorization will remain in force until revoked by me in writing to **PWC**.

The standard fee per session is $135.00. In addition, I agree to pay $100.00 per missed appointment or for any appointment in which 24-hour notice of the cancellation has not been given. This authorization gives **PWC** permission to charge my credit card for these missed appointments.

Credit Card Information:

Type of Card: (circle one) M/C VISA AmEx Discover

Credit Card Number: ____

Expiration Date: ______________/______________
(month) (year)

Card Billing Address: ____

____

____

Card Security Code: ______________________

Cardholder's Name: (print) ____

Cardholder's Signature: ____

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HIPAA PRIVACY STATEMENT: NOTICE OF PRIVACY RIGHTS

THIS NOTICE CONTAINS INFORMATION CONCERNING HOW CONFIDENTIAL MENTAL HEALTH TREATMENT INFORMATION CONCERNING YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND LET US KNOW ANY QUESTIONS THAT YOU MAY HAVE CONCERNING THIS NOTICE. During the process of providing services to you, PassWay Counseling (PWC) will obtain and use mental health and medical information concerning you that is both confidential and privileged. Ordinarily this confidential information will be used in the manner that is described in this statement, and will not be disclosed without your consent, except for the circumstances described in this Notice.

I. USES AND DISCLOSURES OF PROTECTED INFORMATION

A. General Uses and Disclosures Not Requiring the Client's Consent. PassWay Counseling, will use and disclose protected health information in the following ways.

1. Treatment. Treatment refers to the provision, coordination, or management of mental health care and related services by one or more health care providers. For example, PWC therapists and staff involved with your care may use your information to plan your course of treatment and consult with other health care professionals or their staff concerning services needed or provided to you.
2. Payment. Payment refers to the activities undertaken by a health care provider to obtain or provide reimbursement for the provision of health care. For example, PWC and other health care professionals will use information that identifies you, including information concerning your diagnosis, services provided to you, dates of services, and services needed by you, and may disclose such information to insurance companies, to businesses that review bills for health care services and handle claims for payment of health care benefits in order to obtain payment for services. If you are covered by Medicaid, information may be provided to the Sate of Colorado's Medicaid program, including but not limited to your treatment, condition, diagnosis, and services received.
3. Health Care Operations. Health Care Operations mean activities undertaken by health insurance companies, businesses that administer health plans, and companies that review bills for health care services in order to process claims for health care benefits. These functions include management and administrative activities. For example, such companies may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning and accreditation, certification, licensing, and credentialing activities.
4. Contacting the Client. PWC may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
5. Required by Law. PWC will disclose protected health information when required by law. This includes, but is not limited to: (a) reporting child abuse or neglect to the Department of Human Services or to law enforcement; (b) when court ordered to release information; (c) when there is a legal duty to warn a of a threat that a client has made of imminent physical violence, health care professionals are required to notify the potential victim of such a threat, and report it to law enforcement; (d) when a client is imminently dangerous to herself/himself or to others, or is gravely disabled, health care professionals may have a duty to hospitalize the client in order to obtain a 72-hour evaluation of the client; and (e) when required to report a threat to the national security of the United States.
6. Health Oversight Activities. Your confidential, protected health information may be disclosed to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards.
7. Crimes on the premises or observed by PWC personnel. Crimes that are observed by PWC staff, that are directed toward staff, or occur on PWC premises will be reported to law enforcement.
8. Business Associates. Confidential health care information concerning you, provided to insurers or to plans for purposes or payment for services that you receive may be disclosed to business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
9. Research. Protected health information concerning you may be used with your permission for research purposes if the relevant provisions of the federal HIPAA privacy regulations are followed.

10. Involuntary Clients. Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payors, and others, as necessary to provide the care and management coordination needed in compliance with Colorado law.
11. Family Members. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.
12. Emergencies. In life-threatening emergencies, **PWC** staff will disclose information necessary to avoid serious harm and death.

B. Client Release of Information or Authorization. **PWC** and other health care professionals may not use or disclose protected health information in any way without a signed release of information or authorization. When you sign a release of information, or an authorization, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except in to the extent **PWC** has already taken action in reliance thereon.

II. YOUR RIGHT AS A CLIENT

A. Access to Protected Health Information. You have the right to receive a summary of confidential health information concerning you with regard to mental health services needed or provided to you. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask **PWC** staff for the appropriate request form.

B. Amendment of Your Record. You have the right to request that **PWC** or your health care professionals amend your protected health information. **PWC** is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask **PWC** staff for the appropriate request form.

C. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures **PWC** has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask **PWC** for the appropriate request form.

D. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. **PWC** does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask **PWC** for the appropriate request form.

E. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from **PWC** by alternative means or at alternative locations. For example, if you do not want **PWC** to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask **PWC** for the appropriate request form.

F. Copy of this Notice. You have a right to obtain another copy of this notice upon request.

III. ADDITIONAL INFORMATION

A. Privacy Laws. **PWC** is required by state and federal law to maintain the privacy of protected health information. In addition, **PWC** is required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this notice.

B. Terms of the Notice and Changes to the Notice.

C. **PWC** is required to abide by the terms of this notice, or any amended notice that may follow. **PWC** reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains. When the notice is revised, the revised notice will be posed in service delivery sites and will be available upon request.

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C. Complaints Regarding Privacy Rights. If you believe PWC has violated your privacy rights, you have the right to complain to PWC management. Please submit a statement, in writing, addressed to PWC, concerning your complaint and the basis for it. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of PWC that there will be no retaliation for your filing of such complaints.

D. Additional Information: If you desire additional information about your privacy rights at PWC, please ask us any questions that you may have.

IV. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

A. The confidentiality of alcohol and drug abuse patient records maintained by PWC is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

B. Violation of the Federal Law and Regulations by a Program. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

C. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Disclosure may be made concerning any threat made by a client to commit imminent physical violence against another person to the potential victim who has been threatened and to law enforcement.

D. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I UNDERSTAND THESE DISCLOSURES. I HAVE RECEIVED A COPY OF THIS DISCLOSURE STATEMENT AND NOTICE OF PRIVACY RIGHTS.

____

Client Signature

Name________________________________ Date ______________

SCL-90

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, select one of the numbered descriptors that best describes HOW MUCH THAT PROBLEM HAS BOTHERED OR DISTRESSED YOU DURING THE PAST WEEK, INCLUDING TODAY. Circle the number in the space to the right of the problem and do not skip any items. Use the following key to guide how you respond:

Circle 0 if your answer is NOT AT ALL
Circle 1 if A LITTLE BIT
Circle 2 if MODERATELY
Circle 3 if QUITE A BIT
Circle 4 if EXTREMELY

Please read the following example before beginning:

Example: In the previous week, how much were you bothered by:

Backaches 0 (1) 2 3 4

In this case, the respondent experienced backaches a little bit (1).
Please proceed with the questionnaire.

	HOW MUCH WERE YOU BOTHERED BY:	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1.	Headaches	0	1	2	3	4
2.	Nervousness or shakiness inside	0	1	2	3	4
3.	Unwanted thoughts, words, or ideas that won't leave your mind	0	1	2	3	4
4.	Faintness or dizziness	0	1	2	3	4
5.	Loss of sexual interest or pleasure	0	1	2	3	4
6.	Feeling critical of others	0	1	2	3	4
7.	The idea that someone else can control your thoughts	0	1	2	3	4
8.	Feeling others are to blame for most of your troubles	0	1	2	3	4
9.	Trouble remembering things	0	1	2	3	4
10.	Worried about sloppiness or carelessness	0	1	2	3	4
11.	Feeling easily annoyed or irritated	0	1	2	3	4
12.	Pains in heart or chest	0	1	2	3	4
13.	Feeling afraid in open spaces or on the streets	0	1	2	3	4
14.	Feeling low in energy or slowed down	0	1	2	3	4
15.	Thoughts of ending your life	0	1	2	3	4
16.	Hearing voices that other people do not hear	0	1	2	3	4
17.	Trembling	0	1	2	3	4
18.	Feeling that most people cannot be trusted	0	1	2	3	4
19.	Poor appetite	0	1	2	3	4

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SCL-90 (*continued*)

	HOW MUCH WERE YOU BOTHERED BY:	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
20.	Crying easily	0	1	2	3	4
21.	Feeling shy or uneasy with the opposite sex	0	1	2	3	4
22.	Feeling of being trapped or caught	0	1	2	3	4
23.	Suddenly scared for no reason	0	1	2	3	4
24.	Temper outbursts that you could not control	0	1	2	3	4
25.	Feeling afraid to go out of your house alone	0	1	2	3	4
26.	Blaming yourself for things	0	1	2	3	4
27.	Pains in lower back	0	1	2	3	4
28.	Feeling blocked in getting things done	0	1	2	3	4
29.	Feeling lonely	0	1	2	3	4
30.	Feeling blue	0	1	2	3	4
31.	Worrying too much about things	0	1	2	3	4
32.	Feeling no interest in things	0	1	2	3	4
33.	Feeling fearful	0	1	2	3	4
34.	Your feelings being easily hurt	0	1	2	3	4
35.	Other people being aware of your private thoughts	0	1	2	3	4
36.	Feeling others do not understand you or are unsympathetic	0	1	2	3	4
37.	Feeling that people are unfriendly or dislike you	0	1	2	3	4
38.	Having to do things very slowly to insure correctness	0	1	2	3	4
39.	Heart pounding or racing	0	1	2	3	4
40.	Nausea or upset stomach	0	1	2	3	4
41.	Feeling inferior to others	0	1	2	3	4
42.	Soreness of your muscles	0	1	2	3	4
43.	Feeling that you are watched or talked about by others	0	1	2	3	4
44.	Trouble falling asleep	0	1	2	3	4
45.	Having to check and double-check what you do	0	1	2	3	4
46.	Difficulty making decisions	0	1	2	3	4
47.	Feeling afraid to travel on buses, subways, trains	0	1	2	3	4
48.	Trouble getting your breath	0	1	2	3	4
49.	Hot or cold spells	0	1	2	3	4
50.	Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
51.	Your mind going blank	0	1	2	3	4
52.	Numbness or tingling in parts of your body	0	1	2	3	4
53.	A lump in your throat	0	1	2	3	4
54.	Feeling hopeless about the future	0	1	2	3	4
55.	Trouble concentrating	0	1	2	3	4

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SCL-90 (*continued*)

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
56.	Feeling weak in parts of your body	0	1	2	3	4
57.	Feeling tense or keyed up	0	1	2	3	4
58.	Heavy feelings in your arms or legs	0	1	2	3	4
59.	Thoughts of death or dying	0	1	2	3	4
60.	Overeating	0	1	2	3	4
61.	Feeling uneasy when people are watching or talking about you	0	1	2	3	4
62.	Having thoughts that are not your own	0	1	2	3	4
63.	Having urges to beat, injure, or harm someone	0	1	2	3	4
64.	Awakening in the early morning	0	1	2	3	4
65.	Having to repeat the same actions such as touching, counting, washing	0	1	2	3	4
66.	Sleep that is restless or disturbed	0	1	2	3	4
67.	Having urges to break or smash things	0	1	2	3	4
68.	Having ideas or beliefs that others do not share	0	1	2	3	4
69.	Feeling very self-conscious with others	0	1	2	3	4
70.	Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
71.	Feeling everything is an effort	0	1	2	3	4
72.	Spells of terror or panic	0	1	2	3	4
73.	Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
74.	Getting into frequent arguments	0	1	2	3	4
75.	Feeling nervous when you are left alone	0	1	2	3	4
76.	Others not giving you proper credit for your achievements	0	1	2	3	4
77.	Feeling lonely even when you are with people	0	1	2	3	4
78.	Feeling so restless you couldn't sit still	0	1	2	3	4
79.	Feelings of worthlessness	0	1	2	3	4
80.	Feeling that familiar things are strange or unreal	0	1	2	3	4
81.	Shouting or throwing things	0	1	2	3	4
82.	Feeling afraid you will faint in public	0	1	2	3	4
83.	Feeling that people will take advantage of you if you let them	0	1	2	3	4
84.	Having thoughts about sex that bother you a lot	0	1	2	3	4
85.	The idea that you should be punished for your sins	0	1	2	3	4
86.	Feeling pushed to get things done	0	1	2	3	4
87.	The idea that something serious is wrong with your body	0	1	2	3	4
88.	Never feeling close to another person	0	1	2	3	4
89.	Feelings of guilt	0	1	2	3	4
90.	The idea that something is wrong with your mind	0	1	2	3	4

Reference: Derogatis, L.R., Lipman, R.S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale—Preliminary Report. *Psychopharmacol. Bull. 9*, 13–28.

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Zung Self-Rating Depression Scale

Name: ______________________ Date: ____________

Instructions: For every statement in the left column, circle the number of the response that describes how you presently feel.	Never	Sometimes	Most of the time	All the time
1. I feel downhearted, blue, and sad	1	2	3	4
2. Morning is when I feel the best	1	2	3	4
3. I have crying spells or feel like crying	1	2	3	4
4. I have trouble sleeping through the night	1	2	3	4
5. I eat as much as I used to	1	2	3	4
6. I enjoy looking at, talking to, and being with attractive women/men	1	2	3	4
7. I notice that I am losing weight	1	2	3	4
8. I have trouble with constipation	1	2	3	4
9. My heart beats faster than usual	1	2	3	4
10. I get tired for no reason	1	2	3	4
11. My mind is as clear as it used to be	1	2	3	4
12. I find it easy to do the things I used to do	1	2	3	4
13. I am restless and can't keep still	1	2	3	4
14. I feel hopeful about the future	1	2	3	4
15. I am more irritable than usual	1	2	3	4
16. I find it easy to make decisions	1	2	3	4
17. I feel that I am useful and needed	1	2	3	4
18. My life is pretty full	1	2	3	4
19. I feel that others would be better off if I were dead	1	2	3	4
20. I still enjoy the things I used to do	1	2	3	4

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Zung Self-rating Anxiety Scale

Name: ____ Date: ___________________

Listed below are 20 statements. Please read each one carefully and decide how much the statement describes how you have been feeling **during the past week**. Circle the appropriate number for each statement.

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel more nervous and anxious than usual.	1	2	3	4
2. I feel afraid for no reason at all.	1	2	3	4
3. I get upset easily or feel panicky.	1	2	3	4
4. I feel like I'm falling apart and going to pieces.	1	2	3	4
5. I feel that everything is all right and nothing bad will happen.	4	3	2	1
6. My arms and legs shake and tremble.	1	2	3	4
7. I am bothered by headaches, neck and back pains.	1	2	3	4
8. I feel weak and get tired easily.	1	2	3	4
9. I feel calm and can sit still easily.	4	3	2	1
10. I can feel my heart beating fast.	1	2	3	4
11. I am bothered by dizzy spells.	1	2	3	4
12. I have fainting spells or feel faint.	1	2	3	4
13. I can breathe in and out easily.	4	3	2	1
14. I get feelings of numbness and tingling in my fingers and toes.	1	2	3	4
15. I am bothered by stomachaches or indigestion.	1	2	3	4
16. I have to empty my bladder often.	1	2	3	4
17. My hands are usually dry and warm.	4	3	2	1
18. My face gets hot and blushes.	1	2	3	4
19. I fall asleep easily and get a good night's rest.	4	3	2	1
20. I have nightmares.	1	2	3	4

Score Total*: ________

*Score is for healthcare provider interpretation.

Adapted from Zung WWK. A rating instrument for anxiety. *Psychosomatics.* 1971;XII:371-379.
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INFORMED CONSENT FOR ONLINE COUNSELING SERVICES

Passway Counseling (PWC) and its qualified employees, representatives and agents are offering online therapeutic and/or counseling services to meet the needs of its clients and community. Online therapy (also called "Telebehavioral Health") is rapidly growing in utilization. Online services may be satisfactory and helpful to clients in the same way that in-person therapy is. While research concerning the clinical effectiveness of individual telebehavioral health therapy has been proven, the clinical research regarding marital and family therapy online is still ongoing with early positive results. The PWC treatment provider and the client will discuss the client's needs. The PWC treatment provider will determine whether online therapeutic services are right for the client. Clients should check with their medical insurance providers to clarify whether online therapeutic services are covered.

Identity Verification

All new clients are asked to verify their age and identity by providing a scanned image of client's drivers license or other verifiable government-issued identification.

Technology

- PWC treatment providers will use HIPPA compliant video services. (e.g. Zoom or Doxy).
- PWC treatment providers will initiate the session.
- The client is responsible for securing his/ her own computer hardware, internet access, and password security.
- PWC is not liable for confidentiality breaches caused by client error.
- PWC is not responsible for the Client's equipment failure and/or failure of internet service.
- PWC is not responsible for confidentiality lapses that are a result of the client's actions.
- For further information regarding client-therapist confidentiality, please refer to the PWC Disclosure Statement.

Disconnection Problems

If a session is interrupted due to technological failures, PWC and the client will communicate by telephone in an effort to resume the online session. If the session cannot be resumed timely, the PWC provider and client will agree upon another date/ time to complete the session.

Recordings Prohibited

The client will not make an audio or video recording of the therapeutic session.

Records

- PWC Treatment Provider will maintain records of online counseling and/or consultation services.
- All clinical records will be maintained as required by the applicable legal and ethical standards according to the applicable counseling professions licensing boards.
- For further information regarding maintenance of and/or access to records, please refer to the PWC Disclosure Statement.

No Shows or Late Cancellations

A $100 cancellation fee will apply to all missed sessions or any session that is not cancelled and/or rescheduled at least 24 hours in advance of the appointment. The cancellation fee applies to all in-person and/or online sessions.

Client and PWC Communications

PWC prioritizes and values the confidentiality of its clients. However, PWC cannot guarantee confidentiality in the dissemination of information through text or email. Communications by the PWC provider may include, but are not limited to, scheduling and/or re-scheduling appointments; giving information about PWC treatment providers and services offered; requesting statistical information regarding client; requesting payment and/or payment information from client. The conveying of therapeutically sensitive information should occur only in session. Please sign below to indicate your consent for PWC employees to communicate with you through mail, email, text, and by phone.

Client Signature

By signing this form, I acknowledge and affirm the following:

- I am a resident of the State of Colorado.
- I understand the possible risks of engaging in online therapeutic services as described above
- To communicate through the methods stated above.

However, I wish to engage in online therapeutic services.

Client Printed Name ______________________________ Date __________________________

Client Signature __________________________________

Client Printed Name __________________________________ Date ________________________

Client Signature _____________________________________

Client Printed Name __________________________________ Date ________________________

Client Signature _____________________________________

Client Printed Name __________________________________ Date ________________________

Client Signature _____________________________________

Client Printed Name __________________________________ Date ________________________

Client Signature _____________________________________

Client Printed Name __________________________________ Date ________________________

Client Signature _____________________________________