Adolescent and Child Counseling Intake & Insurance Form

Child's Name_____ Age_____ Date of Birth_____

Male **Female** **Other** Ethnicity_____ SS#_____

Place of Birth_____ Religious Affiliation_____

School _____ Grade_____ Currently lives with_____

Spiritual/Cultural Variables to consider?_____

Sibling_____ Age_____ Date of Birth_____

Sibling_____ Age_____ Date of Birth_____

Sibling_____ Age_____ Date of Birth_____

Sibling_____ Age_____ Date of Birth_____

1. Parent's Name_____ Age_____ Date of Birth_____

Address_____

Home Phone_____ Work_____ Cell_____

Marital Status: **Single** **Married** **Separated** **Divorced** Gender_____

Occupation_____ Employer_____

Employment: **full-time** **part-time** **unemployed** **homemaker** **student**

2. Parent's Name_____ Age_____ Date of Birth_____

Address_____

Home Phone_____ Work_____ Cell_____

Marital Status: **Single** **Married** **Separated** **Divorced** Gender_____

Occupation_____ Employer_____

Employment: **full-time** **part-time** **unemployed** **homemaker** **student**

3. Step Parent/Guardian_____Age_____ Date of Birth

Address

Home Phone_____ Work_____ Cell

Marital Status: **Single** **Married** **Separated** **Divorced** Gender

Occupation_____ Employer

Employment: **full-time** **part-time** **unemployed** **homemaker** **student**

How did you hear about Cultivation Counseling?_____

Responsible Party for Billing: Name_____ Phone _____

Address_____ Relationship to client_____

Primary Insurance Company_____

ID#_____ Group #_____

Policy Holder Name_____ Phone _____

Address (if different than client)_____

In case of an emergency we may contact the following person:

Name_____ Relationship_____

Address_____Phone_____

History of Problem

Please describe what concerns you have regarding your child_____

_____

_____

_____

How long has this problem existed?_____

Have there been any significant stressors for the family in the past several years? (losses, births, deaths, moves, hospitalizations, financial problems, divorce)_____

_____

_____

_____

Are there any other agencies involved with the family? (IDHW, Child Welfare, Courts, Etc.)_____

_____

_____

For parents who are divorced, please state custody arrangements_____
_____
_____

Is other biological parent aware that you are bringing their child to counseling? If not, please explain why_____
_____
_____

If adopted, does your child know of this adoption? **YES** **NO**

What age was your child at the time of adoption?_____

Child's Health History

Primary Care Physician_____ Phone _____

(will not be contacted without your consent)

When was your child's last physical?_____ Height_____ Weight_____

Psychiatrist_____ Phone _____

(will not be contacted without your consent)

Pregnancy: Please answer the following about the pregnancy with the child coming to counseling:

How far into your pregnancy did you learn you were pregnant?_____

What prenatal and postnatal care did you receive?_____

_____

_____

Were there any pregnancy complications? Please explain_____

_____

_____

Please list any known developmental delays your child has experienced_____

_____

_____

In the past year my child's physical activity level is best described as:

A. Inactive B. Light Activity (<1 hour/week)

C. Moderate Activity (1-3 hours/week) D. Very Active (4+ hours/week)

In general, my child's health is: **Excellent** **Very Good** **Good** **Fair** **Poor**

Please list any allergies (drug or food):

1._____ 3._____

2._____ 4._____

Medical Problems: Please answer for child receiving counseling:

List all past/present medical problems including surgeries and accidents:

1._____ Age this first occurred_____

2._____ Age this first occurred_____

3._____ Age this first occurred_____

4._____ Age this first occurred_____

Please list any current and past medications (starting with current medications)

Medication	Dose	Year	How Long?	Did it Work?	Doctor

MUST BE COMPLETED FOR CHILDREN 10 YEARS AND OLDER:

Smoking (client/child) **Yes** **Not Currently** **Never Used Tobacco**

□Chew Tobacco How much?_____ When did it start?_____

□Smoke Tobacco How much?_____ When did it start?_____

Alcohol (client/child) **Yes** **Not Currently** **Never Used Alcohol**

Frequency of use:

□Daily □2-3 times/week □Occasional □4-5 times/week □weekends □Never

When was first use?_____ Last use?_____

Check if your child has taken any of the following:

□Marijuana
□Heroin/Opiates
□LSD/Hallucinogens/PCP
□Xanax/Valium/Ativan
□Lortab/Oxycontin/Vicodin
□Amphetamines/Speed
□Cocaine/Crack
□Glue/Paint/Gasoline

Frequency of use_____

Please check any symptoms your child is experiencing:

□Trouble falling asleep
□Wake up in the middle of the night
□Nightmares
□Panic Attacks
□Tension and Anxiety
□Suicidal thoughts
□Self-harm
□Memory problems
□Weight changes
□Inability to concentrate
□Obsessive thoughts
□Recent change in school performance
□Anger
□Hostility toward others
□Acts of violence
□Social isolation
□Strange thoughts
□Stomach aches
□Headaches
□Bedwetting
□Alcohol use
□Drug use
□Sibling conflict
□Other_____

Psychiatric Hospitalizations

Has your child ever been hospitalized for a psychiatric illness? **YES** **NO**

When? _____

Where? _____

Reason? _____

Outpatient Treatment

Has your child ever been to counseling before? **YES** **NO**

Has your child ever been to substance abuse treatment? **YES** **NO**

Agency/Counselor	Phone Number	When/How long?	Reason

Current community resources (support groups, social services, school based services, etc.)?_____
_____

Legal Matters (for client/child receiving counseling):

□Check if the client has ever been arrested. Reason _____

□Check if client has ever been convicted of a felony

□Check if the client is mandated by a court of law to receive counseling

Suicide (for client/child receiving counseling):

□Check if client has ever thought about suicide

If "yes", when was the last time?_____

□Check if client has ever attempted suicide

If "yes", when and how?_____

Does anyone in your family have any current or past legal allegations, arrests, or charges? Please explain:_____
_____
_____
_____

Family History and Major Illnesses

	Drug or Alcohol abuse? (specify)	Major Medical Conditions?	Mental Illness (depression, anxiety, schizophrenia, bipolar disorder, PTSD, Etc.)	Suicide or Suicide Attempts?
Mother				
Father				
Siblings				
Spouse				
Children				
Grandparents				

Violence (for client/child receiving counseling):

□Check if you have ever thought about hurting someone else

If "yes", when was the last time?_____

□Check if you have ever hurt someone else

If “yes”, when was the last time?_____

□Check if you have ever thought about hurting someone now

Family History

Does anyone in your family have a mental illness? Please explain (Depression,Anxiety, Schizophrenia, Bipolar Disorder, PTSD, etc.):

Has a relative ever been hospitalized for a psychiatric illness? Please explain:

Has anyone in your family ever attempted or committed suicide? (Who and when):

Does anyone in your family have a substance abuse problem? Please explain:

Please list any major medical conditions or illnesses in your family. With whom?

Policy for Client Complaints

POLICY STATEMENT

Cultivation Counseling will attempt to resolve client complaints.

REASON FOR POLICY

In the case of a complaint, it is important for both clients and employees to have open avenues to discuss and resolve any concerns. Cultivation Counseling aims to promote communication between therapists, clients, and administrators. The purpose of this policy is to put procedures in place to follow in the case of a complaint.

RESPONSIBILITIES

Responsibilities of Management

- Management shall be responsible for training employees with skills in conflict management.
- Management shall be responsible for handling conflicts which are not resolved at the staff member level.

Responsibilities of Employees

- It is the responsibility of employees to attend trainings offered by Cultivation Counseling.
- It is the responsibility of employees to handle any client complaints with respect and confidentiality.
- It is the responsibility of employees to notify management of any informal client complaints.

PROCEDURES

INFORMAL PROCEDURES

1. Clients are encouraged to discuss concerns directly with the individual staff member in question.
2. If the discussion does not resolve the question, the concern may then be directed to an appropriate supervisor.
3. Every attempt shall be made to handle the concern with respect and confidentiality.

FORMAL PROCEDURES

1. If the Informal Procedures do not resolve the conflict, a written letter of concern may be sent to Cultivation Counseling management.
2. A written letter of response may be sent and a meeting may be scheduled with Cultivation Counseling management following the letter of concern.
3. A copy of both the letter of concern and the letter of response will be saved in the client's file.
4. Clients will not be penalized for filing a complaint.

PROCEDURES FOR OPTUM MEMBERS

Cultivation Counseling shall cooperate with Optum in the complaint investigation and resolution process in regards to Optum members.

1. Written records will be submitted within 14 business days, per Optum's request.

2. Legitimate problems may require adherence to a Corrective Action Plan. Further requirements may be made by Optum in resolving the dispute.

3. Optum members may be directed to contact Optum Idaho Member Services at 1-855-202-0973 on weekdays from 8:00am to 5:00pm.

NOTICE OF PRIVACY PRACTICES

Overview

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the care we provide and may receive such records from others. We use these records to provide or enable other providers to provide quality care, to obtain payment for services provided to you, and to enable us to meet our professional and legal obligations to operate this practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact your selected provider.

When This Practice May Use or Disclose Your Medical Information

Except as described in this Notice of Privacy Practices, we will not use or disclose medical information which identifies you without your written authorization. If you do authorize this practice to use or disclose your medical information for another purpose, you may revoke your authorization in writing at any time.

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operate this practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses, or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities; their efforts to improve health or reduce health care costs; their review of competence, qualifications, and performance of health care professionals; their training programs; their accreditation, certification, or licensing activities; or their health care fraud and abuse detection and compliance efforts.

Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition, or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Products and Services. We may contact you to give you information about products or services related to your treatment, case management, or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also suggest purchasing a product or service for health-related benefits during sessions. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization, and we will disclose whether we receive any payments for recommending products or services.

Required by Law. As required by law, we will use and disclose your health information, but we will limit our use, or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child, elder, or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by federal and California law.

Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request, or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order, warrant, grand jury subpoena, and other law enforcement purposes.

Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Change of Ownership. In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

Fundraising. We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify our Privacy Officer.

Your Medical Information Rights

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your medical information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. Except in limited instances where the restriction involves health care for which you paid out of pocket (as required by law in 42 U.S.C. 13405), we reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your medical information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your medical information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. If we maintain an electronic health record, you have the right to request a copy in an electronic format and direct transmission of an electronic copy to specific individuals. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to Amend or Supplement. You have a right to request that we amend your medical information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your medical information, and will provide you with information about this practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your medical information made by this practice, except that this practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in above for treatment, payment, health care operations, notification and communication with family, specialized government functions, disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities. For certain electronic health records, you have a right to an accounting of disclosures made, including those for treatment, payment, and health care operations for three years prior to the date of your request.

Right to Copy of Notice of Privacy Practices. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer.

Complaints

Complaints about this Notice of Privacy Practices or how this practice handles your medical information should be directed to our Privacy Officer.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Secretary of the United States Department of Health and Human Services Office for Civil Rights: [http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html].

The practice will not retaliate against you if you file a complaint.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected medical information that we maintain, regardless of when it was created or received. We will post the current notice on our online profile or website.

I have read the above privacy practice for Cultivation Counseling:

Name: _____ Date: _____

Authorization for Release of Information

I, _____, Date of Birth _____, authorize **Cultivation Counseling/Northwest College Support** to disclose to and/or obtain from:

_____the following information:

Description of Information to be Disclosed (please initial each to be disclosed):

_____ Complete Copy of Records
_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____

I give special permission to release any information regarding:

_____Substance abuse _____Psychiatric/ Mental Health _____HIV Information

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and coordinate treatment services.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on the following date: _____, or until the 3rd party payor claim is settled.

Conditions: I further understand that **Cultivation Counseling/Northwest College Support** will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act (power of attorney, healthcare surrogate, etc.)

Cultivation Counseling
211 E. Coeur d'Alene Ave #102| Coeur d'Alene , ID 83814 (208)699-6817 |
www.cultivationcounseling.com

INFORMED CONSENT FOR COUNSELING SERVICES

Introduction

Welcome to Cultivation Counseling. This informed consent document is intended to give you general information about our counseling services. This is a legal document; please read it carefully before signing. If you have any questions about signing this document and/or would like a copy of this document please ask your counselor.

Provision of Services

I understand that Cultivation Counseling offers a variety of counseling services including: intake assessment, short term individual counseling, crisis intervention, group counseling, workshops and referral. During the initial assessment, my Cultivation Counseling counselor and I will work together to determine how best to serve my needs. I further understand that appropriate referrals will be provided to me if it is determined that I would be best serviced by a community resource.

Nature of Counseling

I understand that there may be both risks and benefits associated with participation in counseling. Counseling may improve my ability to relate with others, provide a clearer understanding of myself, my values, and my goals, and an ability to deal with everyday stress. I understand that counseling may also lead to unanticipated feelings and change, which might have an unexpected impact on me and my relationships.

Confidentiality

I understand that Cultivation Counseling counselors maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. Records are kept for the period required by ethical and legal guidelines; that period is presently 7 years.

I understand that no records or information about me will be released from Cultivation Counseling without my permission, **except under certain circumstances:**

If I present a serious danger to myself or another person. If I was abused (physically or sexually) or neglected as a child, and if other minor children are currently at risk of being abused or neglected by the person(s) who abused me. If I am under 18 years of age and disclose abuse or neglect to my counselor. If Cultivation Counseling learns that an elderly person or a dependent adult is being abused or neglected. If I have physically or sexually abused a minor child and that child or other minor children are at risk of ongoing abuse. If a valid subpoena is issued for my records, or my records are otherwise subject to a court order or other legal process requiring disclosure.

Contact in Community

It is not abnormal in this size of community to at times see your Cultivation Counseling clinician as you are out in the community. Your clinician will not ever initiate contact and will only if you initiate a typical greeting, match that greeting.

Emergency/Crisis Response
Cultivation Counseling clinicians are often not immediately available by telephone. Clinicians hold regular office hours, but when with clients, will not be available to respond to contact. When the office is closed the telephone is directed to voicemail and is not checked until the next business day. Cultivation Counseling clinicians will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please provide some times when you will be available. If you are unable to reach your clinician and feel that you can't wait for your clinician to return your call, contact your family physician or the nearest emergency room. If you or someone else are in immediate danger call 911. If your clinician will be unavailable for an extended time, they will provide you with the name of a colleague to contact, if necessary.

Supervision
I understand that the Cultivation Counseling clinicians engage in the standard practice of supervision with the other clinicians within the company. During supervision, the clinician makes every effort to avoid revealing the identity of the client. The other professionals are also legally bound to keep the information confidential. Also, if you clinician is currently a supervisee they will inform you of this at the start of therapy services. In signing this form I am consenting to this.

Distance Counseling
Only after establishing a strong therapeutic relationship and on a case by case basis a joint decision between the client and the Cultivation Counseling clinician can be made to allow distance counseling. Distance counseling must be limited within the state that your counselor is licensed. There are also inherent difficulties with relying on technology in the therapeutic process, so do know that there is a possibility of technology failure and alternate methods of service delivery. If this form of counseling is utilized you will need to create a plan with your counselor that addresses anticipated response time, emergency procedures to follow when the counselor is not available, and possible denial of insurance benefits.

Technology and Social Media
Cultivation Counseling has a social media policy that prevents all staff from having social media connection with any current or past clients. There are inherent limits of confidentiality when using technology in the counseling process. I understand that when I initiate a form of technology in the process of receiving counseling services (e.g. email, text, etc.) I understand the limits of confidentiality with this. Cultivation Counseling will utilize the most limited technology possible to provide effective counseling services. In addition you should not expect that Cultivation Counseling will be able to respond to an emergency or crisis communicated via technology and social media in a timely manner. In case of emergency you should call 911.

Attendance Policy
I agree that while I am seeing a Cultivation Counseling clinician or participating in a group, whenever possible, I will notify Cultivation Counseling at least 24 hours in advance if I know I will miss a session.

Fee-Related Issues
I understand that evaluation and intake Interview appointments cost $100 USD. Fees for individual 50-minute therapy sessions is $100 USD. Psycho-Educational assessment costs $115 per hour. I

understand that Cultivation Counseling also charges special fees for other professional services you may require (such as telephone conversations which last longer than 10 minutes, meetings or consultations that you have requested with other professionals, etc.). Payment schedules for other professional services will be agreed to when these services are requested. In circumstances of unusual financial hardship, I may negotiate a fee adjustment or installment payment plan. Once a standing appointment hour is scheduled, I am expected to pay for it (even if it is missed) unless I provide 24-hours advance notice of cancellation.

Procedures

I understand that Cultivation Counseling individualizes counseling procedures to meet my needs. Each counselor may use different specific procedures or techniques. Some of the more common procedures include Cognitive Behavioral Therapy, Client-Centered Therapy, Behavioral Techniques, Relaxation, Problem Solving, and Mindfulness Techniques. I will discuss with my counselor the procedures they will use in my treatment.

Contacting Me

In order to keep my relationship with Cultivation Counseling confidential, the best way to contact me should the need arise is selected/checked below. I am aware that information exchanged over a cell phone and e-mail could be intercepted by an outside party.

☐ Phone Number: _____

☐ E-mail: _____

Consent

I certify that I have read, understand, and agree to abide by the information outlined above regarding my eligibility and use of Cultivation Counseling. I hereby give my consent to authorize Cultivation Counseling to evaluate, treat, and/or refer me to others as needed. I have had the opportunity to discuss any questions regarding the above information. I also certify that I have been given documentation regarding my Health Information Privacy Rights:

Client Signature: _____

Date: _____

Beck's Depression Inventory

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

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 cant stand it

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

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

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

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

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

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

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

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

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 cant even cry even though I want to

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

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

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 anymore

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

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

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

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

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

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

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

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 circled 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

http://www.med.navy.mil/sites/NMCP2/PatientServices/SleepClinicLab/Documents/Beck_Depression_Inventory.pdf