Adult Intake Form

Today's Date: _____

Name: _____ DOB: _____ Age: _____ Gender_____ SS#_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address:_____

Home Ph#_____ Cell Ph#_____ Email: _____

Do you have a Service Animal? YES NO
Would you like to bring your Service Animal to your sessions? YES NO **If yes, please see the Front Desk to go over our Service Animal Policy**

Years of School Completed: _____ Ethnicity: _____ Religion/Spiritual Belief: _____

Place of Employment: _____ How Long? _____ Work Ph#_____

Auto Year: _____ Make: _____ Model: _____ Color: _____ License Plate#:_____

Marital Status: _____ #of Marriages: _____ #of Children: _____

Information about Spouse/Partner:

Name: _____ DOB: _____ Age: _____ SS#_____

Phone #:_____ Email: _____ **Is this your Emergency Contact? Yes No (please complete below)**

Emergency Contact Name: _____ **Relationship**: _____

Address: _____ **Ph. #:**_____

Name of person who referred you to this office: _____

Have you ever seen a therapist or counselor before: ___ No ___ Yes-Name of therapist: _____

Dates and reason for therapy: _____

_____

Did you find therapy/counseling helpful? ____Yes _____No, why didn't it work for you? _____

Please describe why you are seeking DBT counseling: _____

_____

In your opinion, how severe is the problem: _____ Mild _____ Moderate _____Severe _____Debilitating _____I don't think it's a problem, I'm here because someone else believes I should be.

How long do you believe you have struggled with this? _____

On a scale of 1-10, currently what is your motivation to work towards your healing? 1--------2--------3--------4--------5--------6--------7--------8--------9--------10

Which of the following has this problem affected?

_____ Performance at work ____ Relationships with family ____Relationship with peers ____Health

Have you ever been hospitalized in a psychiatric facility? ____Yes ____No

If so, where and when?_____

Problem Behavior History

Have you had any thoughts/urges/actions related to the following? (Please check all that apply):

____ *Suicide* ____*Self-Harm* ___*Homicide* ____*Drug/Alcohol Abuse* ____*Binging/Purging*

If you answered yes to any of the above, please rate the intensity of the thoughts/urges and actions between 0(no intensity) and 10 (high intensity)

____ Suicide ____Self-Harm ___Homicide ____Drug/Alcohol Abuse ____Binging/Purging

Do you currently have thoughts of suicide? _____No ____ Yes

Do you have a history of any previous attempts? (Please provide dates):

Have you ever been referred to a psychiatrist or your family doctor for an evaluation for psychiatric medications? ____ No ____ Yes

Do you need a medication referral? ____ No ___ Yes Are you opposed to medications? ____ No ____ Yes

Are you interested in alternative treatments such as acupuncture, essential oils, yoga, or massage? ____ No ____ Yes

Are you currently taking any medications? ____ No ____ Yes, if so please list medications and dosages below

Height: _____ Weight: _____ Date of last physical exam: _____ Date of last blood tests: _____

Personal physician/psychiatrist Name and Phone:_____

Medication Allergies? ____ No ____ Yes, which meds?_____

If yes, please indicate severity: _____Mild _____Moderate _____Severe

Food Allergies? ____ No ____ Yes, which foods? _____

If yes, please indicate severity: _____Mild _____Moderate _____Severe

Clinician's Initials/Date: _____

Please indicate your drug/alcohol use (if more than one, list in order of drug/alcohol of choice

Type of drug/alcohol (be specific)	Amount Used	Frequency of Use	Date of Last Use

Family Mental Health History

Who primarily raised you?

Where were you raised?

Please list all of you siblings, ages and any known mental health diagnosis:

Name Age Mental Health Issues

_____ _____ _____

_____ _____ _____

_____ _____ _____

Which is true about your biological mother?

____ I don't know if she is alive or deceased ____ She is alive and well ____She is alive but in poor health ____She is deceased

If still living, which is true about the relationship with your biological mother?

____ I have no contact with her as a result of: ____ my decision ____Her decision ____ I was adopted

____ I have a distant relationship with her and we communicate:

____ Weekly ____ Monthly ____Yearly ____ None of the previous

____ I have a close relationship with her and we communicate:

____ Daily ____ 3-5 times a week ____Weekly ____Monthly ____ yearly

Describe any medical problems your mother has/had:

Describe any interpersonal problems you and your mother have:

Which is true about your biological father?

____ I don't know if he is alive or deceased ____ He is alive and well ____He is alive but in poor health ____He is deceased

If still living, which is true about the relationship with your biological father?

____ I have no contact with him as a result of: ____ My decision ____His decision ____ I was adopted

____ I have a distant relationship with him and we communicate:

____ Weekly ____ Monthly ____Yearly ____ None of the previous

____ I have a close relationship with him and we communicate: ___ Daily ____ 3-5 times a week ____Weekly ____Monthly ____ Yearly
Describe any medical problems your father has/had:

Clinician's Initials/Date: _____

Describe any interpersonal problems you and your father have:

What is your current financial situation?
____ Current on all bills ____ slightly behind on a bill or two ____ Behind on all bills including rent/mortgage ____Considering filing for bankruptcy ____Recently filed bankruptcy

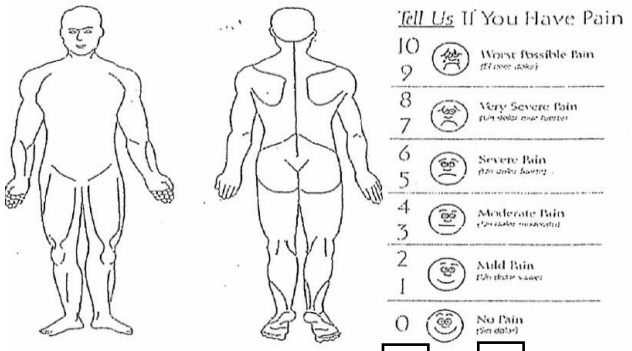
WELL-BEING QUESTIONNAIRE

Directions: On each of the five statements, circle which is closest to how you have felt over the ***last*** week. Note that higher numbers mean better well-being.

	All the time	**Most of the time**	**More than half the time**	**Less than half the time**	**Some of the time**	**At no time**
I feel cheerful and in good spirits	5	4	3	2	1	0
I feel calm and relaxed	5	4	3	2	1	0
I feel active and vigorous	5	4	3	2	1	0
I wake up feeling fresh and rested	5	4	3	2	1	0
My daily life is filled with things that interest me	5	4	3	2	1	0

TOTAL OF ABOVE: _____

PAIN AND BODY CONCERN
Directions: On the diagrams below, please mark the areas where you are experiencing pain and/or concerns about your body. Please explain below:



Do you have medical problems? ☐ No ☐ Yes; explain: _____

Do you have any **children** with chronic health problems? ☐ No ☐ Yes; describe: _____

Do you have a hearing impairment of other physical disability? ☐ No ☐ Yes; describe: _____

Clinician's Initials/Date: _____

Although we will ask to make a copy of your insurance card, we would appreciate if you would fill in the following information:

PRIMARY INSURANCE: _____ ___ Member #_____ Group#_____

Insured Person Name: _____ DOB: _____ SS#:_____ Relationship: _____

Insured Information:
Address: _____ City: _____ State: _____ Zip: _____

Ph#_____ Email: _____ Employer: _____

SECONDARY INSURANCE: _____ Member #_____ Group#_____

Insured Person Name: _____ DOB: _____ SS#:_____ Relationship: _____

Insured Information:
Address: _____ City: _____ State: _____ Zip: _____

Ph#_____ Email: _____ Employer: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

In regards to billing, I authorize the release of any medical or other information necessary to process insurance claims:

☐ Yes ☐ No Signature: _____ Date: _____

I authorize payment of medical benefits to Awake and Aware, LLC. for services rendered:

☐ Yes ☐ No Signature: _____ Date: _____

LEGAL INFORMATION

At Awake and Aware we believe the privacy and security of our clients is of utmost importance, and towards this end we are requesting the following information:

Do you currently have an active restraining order against someone? ___Yes ___ No If Yes, please provide the following information if at all possible:

Name:_____ DOB:_____ Vehicle Information:_____

Description of what this person looks like:_____

Clinician's Initials/Date: ___

For each item below, please indicate your preference, provide your initials on the line to the left and then sign below:

_____ ☐ Yes ☐ No I agree to sign a release of information for Aware and Aware, LLC to communicate with my primary care physician about my coordination of care.

_____ ☐ Yes ☐ No I agree to sign a release of information for Awake and Aware, LLC to communicate with other healthcare provider's about my psychological and/or medical status and/or treatment.

The following medical records may be obtained: _☐_ All medical records OR (circle all that apply below):

Progress notes Discharge plan Treatment plan Psychological evaluation Lab reports Physical exam Medication records

_____ ☐ Yes ☐ No I agree to sign a release of information for Awake and Aware, LLC to confirm appointments for transportation, if need be.

**If you have marked yes any of the above items please discuss signing a release of information with your counselor.

I understand I may revoke these consents to share information at any time and that receipt of treatment is not dependent on my agreement.

I have read Awake and Aware LLC's., practice and privacy policies, and consent to this patient-clinician agreement.

I understand I have the right to refuse to participate in treatment which can be discussed with the Intake Clinician or assigned Clinician.

_____	_____	_____
Client Name (Printed)	Client Signature	Date
_____	_____	_____
Clinician Name (Printed)	Clinician Signature	Date

Policy Name and Number	1.4 Permission/Consent to audiotape/record sessions
Policy for Teletherapy Consent	

10555 Montgomery Blvd. NE Albuquerque, NM 87111 O: (505) 503-7946 F: (505) 503-7947

Consent for Teletherapy Services

In response to COVID-19, Awake & Aware, LLC will be temporarily closed. In the meantime, you have the option to be seen via virtual means. "Teletherapy" includes therapy sessions, consultation, telephone communications, transfer of medical data and education using interactive audio, video or data communication. Awake & Aware, LLC will have a computer in an office room available if you do not have access to a computer to see your therapist. Signing this consent indicates the following:

1) I understand that teletherapy involves the communication of my medical/mental health information both orally and visually.
2) I have the right to opt out of participating in teletherapy and to withdraw my consent at any time without affecting my right to future care or treatment.
3) The laws that protect confidentiality of my medical/mental health information still apply to teletherapy. As such, I understand that the information I disclose or that is disclosed to me during teletherapy sessions is generally confidential. There are exceptions to confidentiality that my therapist has or will further discuss with me.
4) I understand that teletherapy services and care may not be as complete as face-to-face services. I understand that ongoing discussion of my treatment with my therapist is a collaborative endeavor in which I get to express my thoughts and opinions about.
5) Because we are a teaching clinic dedicated to excellence in client care, my teletherapy sessions will still be audio recorded if I have already provided consent to audio record to my therapist. If I am a new client, I will be emailed a consent form for audio recording the session. I have the right to withdraw my consent at any time without affecting my right to future care or treatment.
6) Coaching will still be available for clients in the comprehensive DBT program. Therapists will be available via phone to all clients, which will be the preferred method of communication over email.

Client Printed Name: _____ Date: _____

Client Signature: _____

Clinician Printed Name: _____Date: _____

Clinician Signature: _____

Policy Name and Number	1.4 Permission/Consent to audiotape/record sessions
Policy for the audio recording of sessions for Adults	

10555 Montgomery Blvd. NE Albuquerque, NM 87111 O: (505) 503-7946 F: (505) 503-7947

The counseling process is an involved experience. Professional counselors have found the use of audio tapes an effective means of ensuring clinical excellence for counselors. At Awake & Aware, the purpose for audio recording sessions is twofold:

1) We are a teaching clinic and audio record sessions to evaluate clinician's clinical development and excellence in delivery over time and to ensure clinicians are providing DBT with adherence to the model.
2) We also audio record so that while in treatment, we can evaluate client progress and ability to generalize skills from session to session.

Audio sessions are electronically stored in strict confidence and are routinely destroyed every 3 months. Audio sessions DO NOT become a part of the client's medical record and therefore are not available for release to anyone. Audio sessions are reviewed by the clinical supervisor in addition to other clinicians within the agency *for training and improvement purposes only.*

Audio recording falls under HIPPA regarding limits of confidentiality.

Signing indicates agreement to your therapy sessions being audio recorded and agreement that you understand this policy:

Client Printed Name: _____ Date: _____

Client Signature: _____

Clinician Printed Name: _____Date: _____

Clinician Signature: _____

10555 Montgomery Blvd. NE
Albuquerque, NM 87111
505-503-7946 office 505-503-7947 fax

Dialectical Behavior Therapy Commitments for Adult Participants At Intake

- DBT is an intensive Outpatient Program that requires an 8 to 16-month commitment. This is not something to commit to lightly. The length of the program is necessary to create sustainable behavioral change.
- DBT manages missed sessions in a particular way. The concept of "vacation" is a strategy where clients will be unable to participate in the program for a determined time frame to fully negotiate their commitment. A vacation is an individualized plan that will be discussed if/when necessary by your treating therapist.
- DBT consists of **BOTH** individual therapy and a skills group. Both the individual and group work **MUST** be occurring in order for the individual to stay in the program.
- DBT involves the use of coaching calls between the individual and treating therapist to interrupt problem behavior and to support the individual in making changes to current methods of managing difficulties and issues that may arise during treatment. It is a necessary and important part of the program.
- Phone coaching and crisis intervention protocol will be discussed with your individual therapist.
- You must **CALL** to receive coaching. **Our coaching lines do not have texting capabilities**.
- Transition from your current therapist is a requirement to participate in the DBT program. We do encourage clients to transition effectively from their current therapist to their new DBT therapist.
- DBT assigns homework to clients, which is a necessary part of the change process. Completion is key.
- DBT is a team-based model meaning that client treatment is discussed with therapists on the team in order to maximize the efficacy of the treatment you receive.
- To model skillful "goodbyes," we will continuously attempt to engage our clients in a face to face dialogue prior to drop-out or discharge including phone calls to schedule a final termination session.
- If you do not successfully complete at least 8 months of the DBT program and are discharged, you will not be eligible for return for one year from your discharge date.
- We are a teaching clinic and take adherence seriously. To improve delivery, therapists audio record sessions. Your therapist will discuss this further with you in your first session.
- Awake & Aware also offers a skills group for interested parents or adult family members. If you are interested in learning more about this opportunity, please speak directly with your assigned therapist.

Overall, DBT is a comprehensive treatment that results in sustainable change. If appropriate for you and your family, it requires willingness to stay committed in order to achieve results. We are excited that you have joined us and look forward to working with you towards change.

Assessor: _____ Date: _____

Participant: _____ Date: _____

TJO 5/29/20

Notice of HIPAA Privacy Practices

Awake and Aware, LLC 10555 Montgomery Blvd NE Bldg #2 Albuquerque, NM 87111

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice please ask for assistance.

How I may Use or Disclose Your Mental Health Information

Treatment: The people who provide mental health care services to you will use information about you to determine how best to care for you. I may share mental health information about you to help provide the services you may need and I also may disclose health information about you to people who may be involved in your care, such as physicians or others.

Payment: I may share information about you for payment of our services from your health plan, insurance company or another state or federal payer. For example, I will need to give your health plan information about your mental health status or diagnosis you or your child received, to receive payment for treatment or services provided. I may also tell your health plan or insurer about a treatment you are going to receive so they can approve it and agree to pay for the treatment.

Health Care Operations: I may share health information for accreditations, audits, investigations, inspections, and licensure. This is necessary for the government to monitor the health care system, government programs and laws.

Appointment Reminders and Information: I may call or write to you to remind you that you have an appointment.

Other Uses of Health Information: I will not use or share mental health information about you for any other reason without your written permission. You understand that I cannot take back any disclosures I have already made with your permission, and I am required to keep records of the care that I provided to you.

Your Rights Regarding Your Health Information Right to Inspect and Copy: You have the right to see and receive a copy of the mental health records To inspect and request a copy of your mental health records you may contact me and request the records. If you ask for a copy, I may charge you for the costs of copying and mailing the information to you.

Right to Request a Correction to Misinformation: If you feel that the mental health record I have about you is not right or is incomplete, you may ask me to correct it (called asking for an amendment). You must give me a reason that supports your request. I may deny your request for a correction if it is not in writing or does not include a reason to support the request. I may also deny your request under the following circumstances:
*if you ask me to correct information that was not created by me, unless the person or entity that created the information is no longer available to make the corrections;
* if the information is not part of the health information kept by or for me, or:
* if the information in the record is correct and complete.

Right to an Accounting of Certain Disclosures: I maintain an accounting of certain disclosures of your mental health reports information. You may request an accounting of those disclosures in writing. However, I do not have to account for disclosures related to • treatment; • payment or • health care operations. Your request must state a time period, which may not be longer than six years, and may not include disclosures made before April 14, 2003. Tell me how you want the accounting (for example, on paper or by e-mail). I will give you one accounting per year without cost to you. I may charge you for the accounting if you make more than one request in a 12-month period. If there is a charge, I will tell you what it is and you can decide to cancel your request.

Right to Request Restrictions and Withdraw Restrictions: You have the right to request that I limit the mental health information shared.

Veterans and Specialized Government Functions: If you are/were a member of the armed forces, I may release mental health information about you as required by the Veterans' Administration authorities. I may also release information about you for specialized functions, such as security and military activities.

Public Health Risks: I will share mental health information about you for public health reasons as required by federal or state law:

- To report child abuse or neglect;
- To avert a serious threat to health or safety of self or others;
- To notify the appropriate government authority if I believe a patient or client has been the victim of abuse or neglect. **I will only make a disclosure of abuse or neglect subject to certain requirements when mandated or authorized by law.**

Lawsuits and Other Disputes: If you are involved in a lawsuit or other legal dispute, I may share mental health information about you in response to a court or administrative order. I may also share health information about you in response to a subpoena or other lawful process by someone else involved in the dispute.

Law Enforcement: I may share information about you if asked to do so by a law enforcement official, subject to federal and state laws and regulations:

- In response to a court order, subpoena, warrant, summons or similar process;
- About criminal conduct while in treatment;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime;

If you have requested a restriction to limit the mental health information I use or share, and I have agreed to that restriction, you have the right to withdraw that restriction by placing your request in writing and addressing it to me.

More Restrictive State and Federal Laws: The laws of the state of New Mexico which govern client privacy in behavioral health settings is more restrictive than the Health Insurance Portability and Accountability Act (HIPAA) in several areas. Under state law patient health records are more protected from disclosure than under HIPAA. However, HIPAA provides more opportunity to amend your file and greater access to knowledge about with whom your private health information has been shared. Certain federal laws governing privacy also are more stringent than HIPAA.

I will continue to abide by whichever laws are more stringent. The federal laws include applicable Internet privacy laws, such as the Children's Online Privacy Protection Act and the federal laws and regulations governing the confidentiality of health information regarding substance abuse treatment. State law covering disclosure consents for genetic and HIV testing remain in place.

Right to Request Confidential Communications: You have the right to ask that I communicate with you about your mental health information other than by mailing that information to you, or to ask that I send communications to you about your mental health information to the address you request. I will grant your request if possible.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time.

Complaints: If you believe your privacy rights have been violated, you may complain directly to:

Ralph Rouse, Regional Manager Region VI-New Mexico
Office of Civil Rights, U.S. Dept. of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202.

Please provide as much information as possible so your complaint may be properly investigated. Should you ever file a complaint, it will not be held against you or any member of your family.

Information About This Notice
I may change this notice at any time. I may make the revised or changed notice effective for mental health information I already have about you as well as any information I receive in the future. The notice will show the effective date on the first page. Each time you come to receive mental health services, you may ask for a copy of the current Notice of Privacy Practices. If I change the notice, I will provide the revised notice to you.

"New Mexico is a healthy place in which to live and grow."

Acknowledgement of Receipt of HIPAA Privacy Practices Notice

Federal law requires that all clients be given a copy of the HIPAA Privacy Practices Notice. The HIPAA Privacy Practices Notice describes in detail how client health information is used and shared with others.

All reasonable efforts will be made to protect the privacy of client health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example by e-mail or fax.

Your signature acknowledges that you have received and reviewed Awake and Aware's HIPAA Privacy Practices Notice.

_____ _____

Client Name (Print) Date

_____

Client Signature

If client is a minor under the age of 14, or is unable to give consent, the signature of a parent, legal guardian, or other personal representative is required.

_____ _____

Parent/Legal Guardian or Personal Representative Signature Date

_____ _____

Print Name Relationship to Client

Awake & Aware LLC

Authorization for Release of Protected Health Information
From Mental Health Records

Client Name: _____ DOB: _____

Client Address: _____ City_____ State_____ Zip_____

Phone Number: _____ Last Four Digits of Social Security Number: _____

I authorize Awake & Aware LLC to disclose the following specific protected health information to **and** from:

(name of person and/or organization disclosure is made to) (relationship)

(address of person and/or organization to which disclosure is to be sent)

(_____)_____ (_____)_____
(phone number if known) (fax number if known)

A&A Staff or Client: CHECK MARK all that apply. **Client: Please INITIAL next to all checked information.**

Date(s) of Treatment/Services To Release (optional):

_____ Assessment/Psychic Evaluation
_____ Attendance Documentation
_____ History and Physical Examination
_____ Lab Results
_____ Medication(s)
_____ Number of Kept/Unkept Appointments
_____ Progress Notes
_____ Psychological Testing Results
_____ Transfer/ Termination Summary
_____ Treatment Plan
_____ Other: _____

For Clinician Use Only (CHECK ONE):

☐ Send requested copies now (charges may apply). ☐ File for Reference.

The Purpose of this disclosure authorizes above is: **(check specific purpose(s) for disclosure)**

_____ Progress Reporting
_____ To Provide Information to Family/Caregiver
_____ To Obtain Insurance
_____ Respond to Request for Information
_____ For Permission to Return to Work/School
_____ Other: (specify) _____

I understand that the information used of disclosed may be re-disclosed by the person receiving in and is no longer protected by the federal Health Information Portability and Accountability Act (HIPAA,45 CFR Parts 160 & 164), unless specifically protected by 42 CFR Part 2 governing confidentiality of substance abuse records (see Note to Receiving Agency below). I understand that I may revoke this authorization at any time by notifying the Privacy Officer of Awake & Aware LLC of my desire to revoke this authorization. I understand that if I revoke this authorization, it will not have an effect on information used or disclosed by Awake & Aware LLC prior to my action to revoke. I also understand that I cannot revoke this authorization if drug or alcohol treatment has been ordered by the court as a condition of my sentencing. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain service or my eligibility to receive benefits, *unless* I have been Court ordered for drug or alcohol treatment.

I understand this authorization will expire on (not to exceed 360 days): _____, 20____ or at the end of a specific event. (i.e., completion of substance abuse treatment program, completion of court-ordered group sessions, etc.):

_____

_____/_____ _____/_____
Client Signature (Date) Witness Signature (Date)

_____/_____ _____
Personal Representative's Signature (Date) Descriptions of Representative's Authority

_____
Printed Name of Signature Above

Note to Receiving Agency: This information has been disclosed to you from records projected by Federal confidentiality rules governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and applicable state statutes. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigative or prosecute any alcohol or drug abuse client.

Name _____ **Date** _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

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

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

.

9. Suicidal Thoughts or Wishes

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

.

10. Crying

0 I don't cry any more than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

0 I am no irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I am not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

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 am much less interested in sex now.
3 I have lost interest in sex completely.

Client Name: _____ **Insurance:** _____

I acknowledge that I am financially responsible for full payment of my (or my child's) services:

☐ Insurance-deemed patient portion OR ☐ Self-Pay Rates

Initial_____ I understand that Awake and Aware, LLC staff has contacted my insurance company regarding financial responsibilities, this is not a guarantee of payment. It is possible your financial responsibility will be determined upon submission of claim for rendering services.

Initial_____ I understand if my insurance changes, expires or terminates for any reason, I must notify the billing office immediately. If claims are denied or if a deductible has not been met per insurance payer, I will pay the following self-pay rates until the deductible is met.

Self-Pay Rates: $150.00 – Intake $125.00- Individual Session $75.00- Group Sessions Family Sessions: $100.00

Parenting Group Class- Included in the comprehensive DBT adolescent program

My co-pay will be $_____ for individual sessions
My co-pay will be $_____ for group sessions
My co-pay will be $_____ for family sessions
*Currently, we do not offer multiple services on the same day.

A credit card must be on file for copay amounts; co-payments are due at time of services and will be charged every Monday for services based on your weekly scheduled sessions. If I am unable to meet the specified copay amount during that time, I understand that any future appointment(s) may be cancelled until payment is made in full.

Responsible Party Signature: _____ Date: _____

If client has not paid an invoice exceeding 90 days, Awake & Aware LLC will refer that unpaid balance to a collections agency. Thereafter, client is responsible for paying all associated fees; future services will be cancelled until the account balance is paid in full.

Credit Card Authorization Form

Please complete this form to enroll in credit card auto-pay.

****Credit card billing is completed on Mondays of every week****
****You are only charged for sessions and groups attended****

Client Name: _____ Card Holder Name: _____

VISA **MasterCard** **American Express** **Discover** **Medical Expense/Savings Card**

Credit Card Number: _____ Expiration Date: _____

I authorize Awake & Aware, LLC to charge my credit card for recurring weekly copayments as listed below:

Individual Session	**$ TBD**
Group Session	**$ TBD**

Card Holder Signature: _____ Date: _____

Email: _____

If the client's unpaid invoices are referred to a collections agency, the client shall be responsible for paying all reasonable collections agency fees. No further services will be rendered until the account balance is paid in full.