Pebble Creek Counseling Center
494 East 2400 North Suite B
Tooele, Utah 84074
Fax (435) 249-0360

Patient Information and Consent for Services

Client Information

Client Name:				DOB:		Gender:	SSN:
Address:				City:		State:	Zip:
Home Phone:		Cell:		Work:		Email:	
Emergency Contact:						Phone:	
Primary Physician:						Phone:	

Parent / Guardian Information *(Leave blank if client is an adult. Leave address/phone numbers blank if they are the same as the client.)*

Parent(s) Name:							
Home Address:				City:		State:	Zip:
Home Phone:		Cell:		Work:		Email:	

Responsible Party Information *[The person responsible for paying the patient portion of the bill (leave blank if same as client or parent sections)]*

Name:						DOB:	
Home Address:				City:		State:	Zip:
Home Phone:		Cell:		Work:		Email:	

Insurance Information (Primary Insurance)

Primary Insurance:						Policyholder Name:	
Company Address:						Policyholder DOB:	
City:		State:		Zip:		Subscriber ID#:	
Company Phone:						Group #:	
Employer:						SSN #:	

Insurance Information (Secondary Insurance)

Primary Insurance:						Policyholder Name:	
Company Address:						Policyholder DOB:	
City:		State:		Zip:		Subscriber ID#:	
Company Phone:						Group #:	
Employer:						SSN #:	

The intent of Pebble Creek Counseling is to provide the best possible services based upon a collaborative assessment of your needs and goals. The treatment or services you receive are intended to improve your health and overall quality of life. Because of a variety of factors, a certain outcome or benefit cannot be guaranteed. You have the right to raise questions about services or to seek a second opinion at your expense. You also have the right to withdrawal from services at any time. In signing this form you agree to participate in your treatment and you authorize payment for these services. If you have any questions regarding this form at any point, please discuss this with your therapist.

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Billing and Payment

Payment is required at the time of service. If we will be billing your insurance provider for services, co-pays and co-insurance are required at the time of service. If you have a high deductible that has not been met, you agree to make payment of expected bill at the time of service. You are encouraged to contact your insurance provider to understand your benefits and to obtain any required authorizations for mental health. We will bill your insurance provider for services, work to obtain authorizations as needed, and work to obtain reimbursement from your insurance or other funding sources. However, please be aware that some services may not be covered by your insurance. In all cases payment is your final responsibility. If your insurance denies payment for services, you will be responsible. If insurance is covering part or all of your services, you agree to notify us of any insurance changes when they occur.

Your appointment time is reserved for you. If you cannot make a scheduled appointment please call to cancel or re-schedule at least 24 hours in advance. If you do not call or call less than 24 hours in advance to cancel or re-schedule you will be billed a missed appointment fee, which must be paid prior to scheduling another appointment. If you miss two appointments without calling to cancel, or if you consistently call to cancel or reschedule appointments, we reserve the right to terminate services.

If you have questions regarding payment or billing, please discuss these with us and we will work to try to help you in whatever way we can. By signing this authorization, you are acknowledging and agreeing to the following: Should collection become necessary, I agree to pay all attorney fees, court costs, filing fees, and all collection costs not to exceed 40% of the amount owing which may be assessed by any collection agency retained to pursue the matter. I further agree to pay a finance charge of 1.5% per month (annual percentage rate of 18% per year) of the unpaid balance. I authorize this agency to call on any phone number I provide for any lawful purpose.

Fee Schedule

Initial Evaluation	$175 / hr		
Individual / Family Therapy	$130 / hr	$100 / 45 min	$60 / 30 min
Group Therapy	$40 / hr		
Court Letters	$80 / hr		
Court Appearances	$200 / hr *(including travel time, wait time and actual time in court)*		
Missed Appointment Fee	$25		
Returned Check or Declined Credit Card Fee	$25		

Privacy Policy

- I acknowledge that I was offered a copy of Pebble Creek Counseling's Privacy Policy. I have read and understand this privacy notice, and I understand my rights concerning the use and disclosure of protected health information. _____*(Initial)*

Text / Email Authorization

You have the right to receive or transmit Personal Health Information (PHI) via unsecure methods, such as text messages and emails, though it is not advisable, as information may be accessed by third parties. If you would like to communicate via text or email regarding scheduling appointments or for other issues, you may authorize it.

- I understand that text messages and emails, related to the scheduling of appointments and other issues, are unsecure and the privacy of information transmitted cannot be guaranteed. I understand that I may terminate this authorization at any time.
- _____ *(Initial)* I authorize the use of texts.
- _____ *(Initial)* I authorize the use of emails.

By signing below, I hereby acknowledge that I have read, understand and agree to these terms and consent to mental health treatment.

Client Signature (if over 18):_____ **Date:**_____

Parent/Guardian Signature (if under 18):_____ **Date:**_____

2015 Feb

Pebble Creek Counseling Center

Notice of Patient Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Policy describes how we may use and disclose your PHI in accordance with applicable law. It also describes how you may access and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, appointment reminders, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Michelle Main at (435) 249-0360, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

Signature of understanding _____ Date _____

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score:

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Severity Measure for Generalized Anxiety Disorder—Child Age 11–17

Name:_____ **Age:**_____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During **the PAST 7 DAYS**, I have...	**Never**	**Occasionally**	**Half of the time**	**Most of the time**	**All of the time**	**Item score**
1.	felt moments of sudden terror, fear, or fright	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	felt anxious, worried, or nervous	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	avoided, or did not approach or enter, situations about which I worry	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	left situations early or participated only minimally due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
8.	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
9.	sought reassurance from others due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
10.	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

Youth Outcome Questionnaire (Y-OQ® 2.01)

Name _____ Date _____

PURPOSE: The Y-OQ® 2.01 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common in children and adolescents. You may discover that some of the items do not apply to your child's current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®2.01 you will see that you can easily make your child look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking for your child.

DIRECTIONS:

- Read each statement carefully
- Decide how true this statement is for your child during the **past 7 days.**
- Completely fill the circle that most accurately describes your child during the past week.
- Fill in only one answer for each statement and erase unwanted marks clearly.

Developed by
Gary M. Burlingame, Ph.D., Gawain Wells, Ph.D. and Michael J. Lambert, Ph.D.

For More Information Contact:

AMERICAN PROFESSIONAL CREDENTIALING SERVICES LLC
PO Box 970354
Orem, Utah 84097-0354

E-MAIL:
APCS@OQFAMILY.COM

WEB:
WWW.OQFAMILY.COM
TOLL-FREE: 1-888-MH SCORE, (1-888-647-2673)
FAX: 1-801-434-9730

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. My child wants to be alone more than other children of the same age	O	O	O	O	O
2. My child complains of dizziness or headaches	O	O	O	O	O
3. My child doesn't participate in activities that were previously enjoyable	O	O	O	O	O
4. My child argues or is verbally disrespectful	O	O	O	O	O
5. My child is more fearful than other children of the same age	O	O	O	O	O
6. My child cuts school or is truant	O	O	O	O	O
7. My child cooperates with rules and expectations	O	O	O	O	O
8. My child has difficulty completing assignments, or completes them carelessly	O	O	O	O	O
9. My child complains or whines about things being unfair	O	O	O	O	O
10. My child experiences trouble with her/his bowels, such as constipation or diarrhea	O	O	O	O	O
11. My child gets into physical fights with peers or family members	O	O	O	O	O
12. My child worries and can't get certain ideas off his/her mind	O	O	O	O	O
13. My child steals or lies	O	O	O	O	O
14. My child is fidgety, restless, or hyperactive	O	O	O	O	O
15. My child seems anxious or nervous	O	O	O	O	O
16. My child communicates in a pleasant and appropriate manner	O	O	O	O	O
17. My child seems tense, easily startled	O	O	O	O	O
18. My child soils or wets self	O	O	O	O	O
19. My child is aggressive toward adults	O	O	O	O	O
20. My child sees, hears, or believes things that are not real	O	O	O	O	O
21. My child has participated in self-harm (e.g. cutting or scratching self, attempting suicide)	O	O	O	O	O
22. My child uses alcohol or drugs	O	O	O	O	O
23. My child seems unable to get organized	O	O	O	O	O
24. My child enjoys relationships with family and friends	O	O	O	O	O
25. My child appears sad or unhappy	O	O	O	O	O
26. My child experiences pain or weakness in muscles or joints	O	O	O	O	O
27. My child has a negative, distrustful attitude toward friends, family members, or other adults.	O	O	O	O	O
28. My child believes that others are trying to hurt him/her even when they are not	O	O	O	O	O
29. My child threatens to, or has run away from home	O	O	O	O	O
30. My child experiences rapidly changing and strong emotions	O	O	O	O	O

PARENT|GUARDIAN

Name _____ Date _____

PURPOSE: The Y-OQ® 2.01 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common in children and adolescents. You may discover that some of the items do not apply to your child's current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®2.01 you will see that you can easily make your child look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking for your child.

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	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
31. My child deliberately breaks rules, laws, or expectations	O	O	O	O	O
32. My child appears happy with her/himself	O	O	O	O	O
33. My child sulks, pouts, or cries more than other children of the same age.	O	O	O	O	O
34. My child pulls away from family or friends	O	O	O	O	O
35. My child complains of stomach pain or feeling sick more than other children of the same age.	O	O	O	O	O
36. My child doesn't have or keep friends	O	O	O	O	O
37. My child has friends of whom I don't approve	O	O	O	O	O
38. My child believes that others can hear her/his thoughts or that s/he can hear the thoughts of others	O	O	O	O	O
39. My child engages in inappropriate sexual behavior (e.g. sexually active, exhibits self, sexual abuse towards family members or others)	O	O	O	O	O
40. My child has difficulty waiting his/her turn in activities or conversations	O	O	O	O	O
41. My child thinks about suicide, says s/he would be better off if s/he were dead	O	O	O	O	O
42. My child complains of nightmares, difficulty getting to sleep, oversleeping, or waking up from sleep too early	O	O	O	O	O
43. My child complains about or challenges rules, expectations or responsibilities	O	O	O	O	O
44. My child has times of unusual happiness or excessive energy	O	O	O	O	O
45. My child handles frustration or boredom appropriately	O	O	O	O	O
46. My child has fears of going crazy	O	O	O	O	O
47. My child feels appropriate guilt for wrongdoing	O	O	O	O	O
48. My child is unusually demanding	O	O	O	O	O
49. My child is irritable	O	O	O	O	O
50. My child vomits or is nauseous more that other children of the same age.	O	O	O	O	O
51. My child becomes angry enough to be threatening to others	O	O	O	O	O
52. My child seems to stir up trouble when bored	O	O	O	O	O
53. My child is appropriately hopeful and optimistic	O	O	O	O	O
54. My child experiences twitching muscles or jerking movement in face, arms, or body	O	O	O	O	O
55. My child has deliberately destroyed property	O	O	O	O	O
56. My child has difficulty concentrating, thinking clearly, or attending to tasks	O	O	O	O	O
57. My child talks negatively, as though bad things were all his/her fault	O	O	O	O	O
58. My child has lost significant amounts of weight without medical reason	O	O	O	O	O
59. My child acts impulsively, without thinking of the consequences	O	O	O	O	O
60. My child is usually calm	O	O	O	O	O
61. My child will not forgive her/himself for past mistakes	O	O	O	O	O
62. My child lacks energy	O	O	O	O	O
63. My child feels that he/she doesn't have any friends, or that no one likes him/her	O	O	O	O	O
64. My child gets frustrated and gives up, or gets upset easily	O	O	O	O	O

PARENT/GUARDIAN

PARENT / GUARDIAN

Area Logo

PC1

Parent Report Measures for Children and Adolescents
SDQ(P)04-10

Facility Name: _____

Code: |_|_|_|_|

Please used gummed label if available

Patient or Client Identifier: |_|_|_|_|_|_|_|_|

Surname:

Other names:

Date of Birth: ____/____/____ Sex: Male ☐1 Female ☐2

Address:

Instructions: For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behaviour **over the last six months.**

Strengths and Difficulties Questionnaire	Not True	Somewhat True	Certainly True
1. Considerate of other people's feelings	O	O	O
2. Restless, overactive, cannot stay still for long	O	O	O
3. Often complains of headaches, stomach-aches or sickness	O	O	O
4. Shares readily with other children, for example toys, treats, pencils	O	O	O
5. Often loses temper	O	O	O
6. Rather solitary, prefers to play alone	O	O	O
7. Generally well behaved, usually does what adults request	O	O	O
8. Many worries or often seems worried	O	O	O
9. Helpful if someone is hurt, upset or feeling ill	O	O	O
10. Constantly fidgeting or squirming	O	O	O
11. Has at least one good friend	O	O	O
12. Often fights with other children or bullies them	O	O	O
13. Often unhappy, depressed or tearful	O	O	O
14. Generally liked by other children	O	O	O
15. Easily distracted, concentration wanders	O	O	O
16. Nervous or clingy in new situations, easily loses confidence	O	O	O
17. Kind to younger children	O	O	O
18. Often lies or cheats	O	O	O
19. Picked on or bullied by other children	O	O	O
20. Often volunteers to help others (parents, teachers, other children)	O	O	O
21. Thinks things out before acting	O	O	O
22. Steals from home, school or elsewhere	O	O	O
23. Gets along better with adults than with other children	O	O	O
24. Many fears, easily scared	O	O	O
25. Good attention span, sees chores or homework through to the end	O	O	O

SOURCE: Mental Health National Outcomes and Casemix Collection: Overview of Clinician-Rated and Consumer Self-Report Measures V1.50, Mental Health & Suicide Prevention Branch, Department of Health and Ageing

PARENT / GUARDIAN

Please turn over – there are a few more questions on the other side

Do you have any other comments or concerns?

	Over the last six months, have your child's teachers complained of:	No	A Little	A Lot
36.	Fidgetiness, restlessness or overactivity	O	O	O
37.	Poor concentration or being easily distracted	O	O	O
38.	Acting without thinking, frequently butting in, or not waiting for his or her turn	O	O	O

		No	Yes – minor difficulties	Yes – definite difficulties	Yes – severe difficulties
26	Overall, do you think that your child has difficulties in any of the following areas: emotions, concentration, behaviour or being able to get along with other people?	O	O	O	O

If you have answered "Yes", please answer the following questions about these difficulties:

		Less than a month	1-5 months	6-12 months	Over a year
27	How long have these difficulties been present?	O	O	O	O

		Not at all	A little	A medium amount	A great deal
28	Do the difficulties upset or distress your child?	O	O	O	O
	Do the difficulties interfere with your child's everyday life in the following areas?				
	29. HOME LIFE	O	O	O	O
	30. FRIENDSHIPS	O	O	O	O
	31. CLASSROOM LEARNING	O	O	O	O
	32. LEISURE ACTIVITIES	O	O	O	O
33	Do the difficulties put a burden on you or the family as a whole?	O	O	O	O

Signature_____ Date_____

Mother/Father/Other (please specify):_____

Thank you very much for your help.

SDQ (P) 04-10 SELF–REPORT MEASURE (2of 2)

SOURCE: Mental Health National Outcomes and Casemix Collection: Overview of Clinician-Rated and Consumer Self-Report Measures V1.50, Mental Health & Suicide Prevention Branch, Department of Health and Ageing