



Behavioral Health & Cognitive Therapy Center Office Information and Patient-Therapist Agreement

Welcome to Summit Medical Group's Behavioral Health and Cognitive Therapy Center (BHCTC). We thank you for choosing us for your counseling needs. This Office Information and Patient-Therapist Agreement (Agreement) includes important information about BHCTC's services, office policies and expectations. **It is important that you read this Agreement carefully and raise any questions you may have about it with your clinician.** When you sign this Agreement, it creates an actual agreement between you and your clinician and both you and your clinician are expected to act in accordance with all of its terms, and that your clinician will expect you to do the same. You may revoke this Agreement in writing at any time; however, you may still be held to the Agreement's payment obligations even though you have decided to revoke it. Please read the following information carefully and feel free to ask your clinician any questions during your meeting together. After reading this Agreement please sign it at the bottom and give it back to the receptionist.

Counseling and Psychotherapy Services

Counseling and psychotherapy are treatments that help patients confront issues and feelings that are causing them problems. These treatments call for an active effort on your part during the sessions and may require you to work on issues between sessions. Treatment can have many benefits and some side effects that may be unpleasant. The benefits may include reduced feelings of anxiety and depression, better relationships with others, and solutions to specific problems. However, because treatment often involves discussing unpleasant parts of your life, you may experience temporary feelings like frustration, anger, guilt, and sadness. People who usually get the most benefit from treatment are those that keep their appointments regularly and are committed to making changes in their lives. The BHCTC cannot guarantee how much benefit you will personally experience.

Sessions

Your first session with your clinician will involve an evaluation of what problems appear most important to work on and what treatment needs you have. By the end of this first evaluation time, your clinician will give you their thoughts about your work together and what treatment they feel will be most helpful. This first session will evaluate your needs and determine if your clinician and the BHCTC is right for your treatment. This initial session will also help you to determine if you feel comfortable receiving treatment at the BHCTC.

If you and your clinician choose to begin treatment together, you will be scheduled for treatment sessions at a length and frequency determined by you and your clinician. ***The goal***

of treatment is to get you feeling and functioning better as efficiently as possible and we therefore limit the total number of sessions to approximately 12 or three-months of weekly therapy sessions. (For a better understanding of BHCTC’s approach please read the “What is Cognitive Behavioral Therapy” handout in this packet).

You will receive the best benefit from treatment if you come to your appointments regularly. If you must cancel an appointment, this Agreement represents your promise that you will do so at least 24 hours in advance of your scheduled time. If you do not cancel 24 hours in advance, the BHCTC will need to charge you for a missed session because your clinician will have reserved that treatment time for you and will be unable to use that time to see any other patient. A missed appointment can not be billed to your insurance carrier, which means that you will be responsible for paying the BHCTC in full a \$100 cancellation fee for the missed appointment. The BHCTC recognizes that emergencies or other unplanned events do arise that can not be helped (flat tires, sick children, family emergencies), so this Agreement allows you to cancel one (1) appointment less than 24 hours in advance within any 6 month period without any charge to you. If you cancel more than that, you understand and agree that BHCTC can bill you \$100 for each missed appointment.

We try very hard to accommodate our patients and to see them in a timely manner; however, there is often a waiting list for individuals seeking treatment due to a lack of available session times. Therefore, if you miss 4 appointments where you fail to give 24 hours cancellation notice within any 12 month period you may be dismissed from BHCTC. You are only eligible to reapply for treatment after 12-months has passed from the time of your dismissal.

Working with your Physician

Many of our patients have been referred to us by their Summit Medical Group (SMG) physicians and/or other physicians not affiliated with SMG. We find that contacting these physicians about your treatment ensures that your overall care is uniform and effective. It is our position that notifying your treating physician about the treatment BHCT is providing to you, and having your physician give us background about your medical history, improves your overall treatment. If your physician is an SMG provider, by signing this, you are authorizing and permitting the BHCT to contact your physician by the method determined by BHCT (e.g., phone, letter). If you are an SMG patient, please note that although the BHCTC and SMG share an electronic health record system, your session notes—the notes written by your clinician that reflect the things you have discussed during your sessions—are not accessible by SMG physicians and personnel. SMG physicians will, however, have access to a list of medications the BHCTC prescribes.

If your physician is not affiliated with SMG, the BHCTC may have you sign the Consent to Share Information Form to discuss your treatment with your provider. The BHCTC may also attempt to contact them by letter or phone stating that we have begun treatment with you. We will also ask them to contact us if they have any questions or concerns about your treatment. **If there is any specific information you do not want your treating physician to know, please discuss this with your treating clinician.**

Medication Appointments

If your clinician believes you would benefit from psychiatric medications he/she will either speak to your treating physician, refer you to a local psychiatrist or make an appointment with the BHCTC psychiatrist for a medication evaluation. We require that you are in active psychotherapy to utilize our psychiatrist. Treatment with our psychiatrist is considered short-term and once you are stabilized on your medication you will be referred back to your treating physician who will monitor your medication and provide refills.

Professional Fees

The BHCTC's initial intake assessment fee is \$255. The 45-minute follow-up session fee for treatment is \$192. We also charge the \$192 fee (or break down of the hourly cost for periods of less than 45 minutes) for other services including report writing, attending authorized meetings with other professionals, preparation of records or treatment summaries, telephone conversations lasting longer than 15 minutes, and time spent in any other service you request of us. This fee for non-session services may or may not be reimbursed by your insurance company. If you become involved in any legal proceedings that require our participation, you will be required to pay for our professional time even if we are called to testify by another party. Because of the time-consuming nature of legal involvement, we charge \$600 per hour for preparation and attendance at any legal proceeding. These services are usually not reimbursed by your insurance company.

Billing and Payments

This Agreement requires that you pay for each session you have at the BHCTC at the end of each session. Where applicable, we will bill the insurance company for you, but you are required to pay your co-payment and any deductible at the end of each session. As a courtesy, we will check with your insurance carrier and will make reasonable attempts to determine what you will need to pay at each session; however, we can not guarantee that the information provided to us is correct and you are ultimately responsible for determining your insurance coverage and for paying the BHCTC for treatments provided to you that are not covered by your insurance plan. **By signing this Agreement you agree that you will pay any outstanding amounts due and owing to the BHCTC.** In circumstances of financial hardship, please contact SMG's business office to discuss payment options. If you have not made payments on your account within 2 scheduled sessions, and no payment arrangements have been made, the BHCTC reserves the option to use legal means to obtain payment from you. This may involve hiring a collection agency or going to small claims court.

Insurance Reimbursement

If you have health insurance, your behavioral health treatments may be covered in whole or in part. The BHCTC will assist you in determining your insurance coverage and will help you fill out any forms needed. Many managed care plans often require an authorization before treatment can begin. You may be required to contact your insurance company to obtain this authorization and/or receive it from your primary care physician.

Many managed care plans limit counseling and therapy services to short-term treatment designed to work out specific problems that prevent people from living and working as they normally do. As this is the BHCTC's model of treatment, this often works out well. Where necessary, we may request more sessions from the managed care plan. In order to do so, we are typically required to complete the insurance company's forms which may include providing your diagnosis, the reasons you have sought treatment from the BHCTC, the symptoms you are suffering, and how long we believe treatment will or should continue. The information provided will become part of the insurance company's files. Insurance companies are obligated to keep this information confidential; however, please note that the BHCTC has no control over the handling of this information by the insurance company.

If you receive treatment from one of our NJ Licensed Psychologists, your insurance company may request that you authorize the psychologist to disclose certain confidential information in order to obtain insurance coverage benefits for these services. This disclosure can occur only if it is pursuant to a valid authorization and the information is limited to: 1) administrative information (name, age, sex, fees, dates, nature of sessions, etc.); 2) diagnostic information; 3) the status of the patient (voluntary/involuntary; inpatient/outpatient); 4) the reason for continuing psychological services (limited to an assessment of the current level of functioning and the level of distress both rated as mild, moderate, severe or extreme); and 5) a prognosis, limited to the estimated minimal length of treatment. If the Insurance Company has reasonable cause to believe that the psychological treatment in question may not be usual, customary or is unreasonable, it may request an independent review of such treatment by an independent review committee.

While a lot can be accomplished in short-term therapy, some people feel they need more services after their insurance benefits end. If this is the case with you, we will discuss what our fees are and the best way for you to arrange payment in order to receive continued treatment. If your insurance company does not allow us to see you after your benefits end, we will be happy to assist you in finding another therapist who will work well with you.

It is also important to remember that you always have the right to pay for your treatment yourself to avoid any insurance issues discussed above.

Contacting Us

You may contact the BHCTC office during regular business hours and during our evening hours to make or change appointments. Our staff is available to assist you with insurance questions. Our clinicians make all reasonable efforts to return telephone calls to patients promptly. If you have an emergency or crisis and are unable to reach your clinician, please do not hesitate to call 911, your local hospital's emergency room or a crisis center such as Overlook Hospital's Crisis Center (908-522-3586) for immediate help.

Professional Records

HIPAA requires that we maintain the confidentiality of "Protected Health Information" (PHI). You are permitted to examine or request a copy of your clinical record upon submitting a

written request to do so in accordance with HIAA. Please note that there are some exceptions to release of these records and we will promptly advise you if we are unable to release these records to you upon receipt of your signed authorization. As behavioral health records may be misinterpreted and/or cause undue stress to patients, we strongly encourage you to initially review them in your clinician's presence, or have them forwarded to another mental health professional so you can discuss the contents with that professional. We charge a copying fee for these records, as is permitted by New Jersey regulation.

Patient Rights

HIPAA provides you with several expanded rights with regard to your Clinical Records and disclosures of protected health information (PHI). These rights include: requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; the location to which PHI disclosures were sent, recourse to any complaints you have about the policies and procedures we have pertaining to the care of your PHI, the right to a paper copy of this Agreement (the attached Notice form) and our privacy policies and procedures. Our staff is happy to discuss any of these rights with you.

Minors

If you are under 18 years of age, please be aware that the law provides your parents with the right to examine your treatment records, with certain exceptions. Specifically, New Jersey law provides that where a minor patient is between the age of 14 and 18, treatment records by a licensed psychologist or a social worker may only be released where both the patient and the patient's parent or legal guardian has signed an authorization. A parent or legal guardian of a minor patient treated by a licensed psychologist or social worker who is under the age of 14 may access medical records without the minor patient's authorization.

It is our policy to ask minor's parents to agree to give up this right so that our work together may be more confidential. If they agree, we will only give them very general information about the minor's treatment or any information the minor patient and the clinician agree upon.

If you are a divorced or single parent of a minor, we require that both parents consent and are involved with the minor's treatment. This is to ensure that treatment goals are agreed upon and can be maintained when the minor is with either parent. **Even if you refuse to have your child's other parent notified of treatment, your child's other parent may be entitled to request and receive a copy of the minor child's treatment records where permitted by New Jersey law.** If you are concerned about the release of these treatment records to your child's other parent, please speak with your child's clinician. In the event the other parent's parental rights have been terminated by the Court, please provide a copy of the Court's Order to ensure that your child's records are not released to the terminated parent. The BHCTC reserves the right, in its sole discretion, to refuse to treat a child in cases where the BHCTC determines that both parents consent is necessary.

Confidentiality

In general, our work together is private and the law protects your privacy. In most situations (and subject to certain exceptions), we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA and state laws and regulations. There are other situations that require only that you provide written, advance consent (Please see the Notice of Privacy Practice for more information about these situations).

While such situations are unusual in our practice, we are required to reveal otherwise confidential information about your treatment in circumstances such as the following:

- If we have reasonable cause to believe that a child has been subject to abuse, we must report it to the Division of Youth and Family Services. Once such a report is filed, we may be required to provide additional information.
- If we have reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation, and we believe that the disclosure is necessary to prevent serious harm to that adult or other potential victims, we will report the information to the county adult protective service provider. Once such report is filed, we may be required to provide additional information.
- If a patient communicates a threat, or if we believe the patient presents a threat of imminent serious physical violence against a readily identifiable individual, we may be required to make protective actions. These actions may include notifying the potential victim, contacting the police, or seek the patient's hospitalization.
- If we believe a patient presents a threat of imminent serious physical harm to him/herself, we may take various protective actions.

Clinician Supervision

In order to ensure that you and/or your child receive treatment that is of the highest quality, our clinicians are subjected to both individual and group supervision to discuss certain patient matters related to patients they treat. This helps ensure that your clinician is utilizing the most effective therapeutic approach. All clinicians at the BHCTC are strictly bound by confidentiality requirements related to the patients they treat, as well as patients discussed in supervision.

Feel free to discuss any concerns you have with our staff or your clinician. We will be happy to discuss the matter with you or refer you for legal advice if we can not adequately answer your questions.

Again, we want to thank you for choosing SMG and the BHCTC for your treatment needs. We hope the information provided in this Agreement makes you an informed consumer of behavioral health services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Signature

Date

Print Name



**Behavioral Health &
Cognitive Therapy Center**

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PATIENT NOTICE OF CANCELLATION POLICY

THIS NOTICE DESCRIBES IN DETAIL THE CANCELLATION POLICY OF THE SUMMIT MEDICAL GROUP BEHAVIORAL HEALTH AND COGNITIVE THERAPY CENTER. PLEASE REVIEW IT CAREFULLY.

I. What This Is

This notice describes in detail, the cancellation policy of the Behavioral Health and Cognitive Therapy Center (BHCTC)

II. Our Policy

We require patients to keep all scheduled appointments. If you must cancel an appointment you must do so **24 hours prior** to the appointment time. If you do not cancel **prior to 24 hours** the BHCTC will charge for that session.

III. Why do we have this policy?

Patients best benefit from treatment when they come on a regular basis. Furthermore, your Clinician has reserved that time for you. If you do not give enough notice of cancellation the Clinician will be unable to use that time to see any other patient.

IV. What if I have an emergency?

The BHCTC of course recognizes that emergencies or other unplanned events do arise (i.e. flat tire, sick children, family emergencies, etc.), that is why we allow you to cancel **one (1)** appointment less than **24 hours** in advance without any charge to you, **within any 6 month period**. However, if you cancel more than that you will be billed for each missed appointment.

V. How much would I be billed if I miss more than two appointments? Why?

You will be billed **\$100**. A missed appointment cannot be billed to your insurance carrier, which means you will be responsible for paying the full **\$100** cancellation fee for the appointment.

People who usually get the most benefit from treatment are those that keep their appointments regularly and are committed to making changes in their lives. We look forward to continued treatment with you, as we aim to help you feel better and lead more productive lives.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS NOTICE AND AGREE TO ITS TERMS.

Signature

Print Patient Name

The Mood Disorder Questionnaire

INSTRUCTIONS: Please answer each question as best you can.

YES NO

1. Has there ever been a period of time when you were not your usual self and...
- | | | |
|--|-----------------------|-----------------------|
| ... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | <input type="radio"/> | <input type="radio"/> |
| ... you were so irritable that you shouted at people or started fights or arguments? | <input type="radio"/> | <input type="radio"/> |
| ... you felt much more self-confident than usual? | <input type="radio"/> | <input type="radio"/> |
| ... you got much less sleep than usual and found that you didn't really miss it? | <input type="radio"/> | <input type="radio"/> |
| ... you were more talkative or spoke much faster than usual? | <input type="radio"/> | <input type="radio"/> |
| ... thoughts raced through your head or you couldn't slow your mind down? | <input type="radio"/> | <input type="radio"/> |
| ... you were so easily distracted by things around you that you had trouble concentrating or staying on track? | <input type="radio"/> | <input type="radio"/> |
| ... you had much more energy than usual? | <input type="radio"/> | <input type="radio"/> |
| ... you were much more active or did many more things than usual? | <input type="radio"/> | <input type="radio"/> |
| ... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | <input type="radio"/> | <input type="radio"/> |
| ... you were much more interested in sex than usual? | <input type="radio"/> | <input type="radio"/> |
| ... you did things that were unusual for you or that other people might have thought were excessive, foolish or risky? | <input type="radio"/> | <input type="radio"/> |
| ... spending money got you or your family in trouble? | <input type="radio"/> | <input type="radio"/> |
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? YES NO
3. How much of a problem did any of these cause you - like being able to work; having family, money or legal troubles; getting into arguments or fights?
 No problem Minor problem Moderate problem Serious problem
- 4.* Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? YES NO
- 5.* Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? YES NO

This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.
See first pages of pad for scoring algorithm.

*Derived from Hirschfeld RM. *Am J Psychiatry*. 2000;157(11):1873-5.

Versión en español en el reverso

Patient Health Questionnaire™ (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name _____ Age _____ Sex: Female Male Today's Date _____

1. During the <u>last 4 weeks</u> , how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain in your arms, legs, or joints (knees, hips, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Menstrual cramps or other problems with your periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE CODING: Som Dis if at least three of #1a-m are "a lot" and lack an adequate biol explanation. Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all). Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. Questions about anxiety.

- a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic? NO YES

If you checked "NO", go to question #5.

- b. Has this ever happened before?
- c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?
- d. Do these attacks bother you a lot or are you worried about having another attack?

4. Think about your last bad anxiety attack.

- a. Were you short of breath? NO YES
- b. Did your heart race, pound, or skip?
- c. Did you have chest pain or pressure?
- d. Did you sweat?
- e. Did you feel as if you were choking?
- f. Did you have hot flashes or chills?
- g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?
- h. Did you feel dizzy, unsteady, or faint?
- i. Did you have tingling or numbness in parts of your body?
- j. Did you tremble or shake?
- k. Were you afraid you were dying?

5. Over the last 4 weeks, how often have you been bothered by any of the following problems?

- Not at all Several days More than half the days
- a. Feeling nervous, anxious, on edge, or worrying a lot about different things

If you checked "Not at all", go to question #6.

- b. Feeling restless so that it is hard to sit still
- c. Getting tired very easily
- d. Muscle tension, aches, or soreness
- e. Trouble falling asleep or staying asleep
- f. Trouble concentrating on things, such as reading a book or watching TV
- g. Becoming easily annoyed or irritable

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

6. Questions about eating.

- | | | |
|---|--------------------------|--------------------------|
| a. Do you often feel that you can't control <u>what</u> or <u>how much</u> you eat? | NO | YES |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you often eat, <u>within any 2-hour period</u> , what most people would regard as an unusually <u>large</u> amount of food? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |

If you checked 'NO' to either #a or #b, go to question #9.

- | | | |
|--|--------------------------|--------------------------|
| c. Has this been as often, on average, as twice a week for the last 3 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. In <u>the last 3 months</u> have you <u>often</u> done any of the following in order to avoid gaining weight ? | NO | YES |
| a. Made yourself vomit? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Took more than twice the recommended dose of laxatives? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Fasted — not eaten anything at all for at least 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Exercised for more than an hour specifically to avoid gaining weight after binge eating? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week? | NO | YES |
| | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--|--------------------------|--------------------------|
| 9. Do you ever drink alcohol (including beer or wine)? | NO | YES |
| | <input type="checkbox"/> | <input type="checkbox"/> |

If you checked "NO" go to question #11.

- | | | |
|--|--------------------------|--------------------------|
| 10. <u>Have any of the following happened to you more than once in the last 6 months?</u> | NO | YES |
| a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health | <input type="checkbox"/> | <input type="checkbox"/> |
| b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities | <input type="checkbox"/> | <input type="checkbox"/> |
| c. You missed or were late for work, school, or other activities because you were drinking or hung over | <input type="checkbox"/> | <input type="checkbox"/> |
| d. You had a problem getting along with other people while you were drinking | <input type="checkbox"/> | <input type="checkbox"/> |
| e. You drove a car after having several drinks or after drinking too much | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. If you checked off <u>any</u> problems on this questionnaire, how <u>difficult</u> have these problems 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

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank. Alc Abu if any of #10a-e is 'YES'.

12. In the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
a. Worrying about your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Your weight or how you look	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Little or no sexual desire or pleasure during sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. The stress of taking care of children, parents, or other family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Stress at work outside of the home or at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Financial problems or worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Having no one to turn to when you have a problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Something bad that happened <u>recently</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Thinking or dreaming about something terrible that happened to you in the <u>past</u> - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?

NO YES

14. What is the most stressful thing in your life right now? _____

15. Are you taking any medicine for anxiety, depression or stress?

NO YES

16. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

a. Which best describes your menstrual periods?

Periods are unchanged

No periods because pregnant or recently gave birth

Periods have become irregular or changed in frequency, duration or amount

No periods for at least a year

Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive

b. During the week before your period starts, do you have a serious problem with your mood - like depression, anxiety, irritability, anger or mood swings?

NO (or does not apply) YES

If YES: Do these problems go away by the end of your period?

Have you given birth within the last 6 months?

Have you had a miscarriage within the last 6 months?

Are you having difficulty getting pregnant?

DASS₂₁

Name:

Date:

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Summit Medical Group

ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgment of Privacy Practice Notice

I have received a copy of the Summit Medical Group's Notice of Privacy Practices.

Patient's Name

Date of Birth

Signature of Patient/Parent/Guardian

Date

II. Designation of Certain Relatives, Close Friends and Other Caregivers

INITIAL

UPDATE

I agree that Summit Medical Group may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Summit Medical Group will *disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.*

I wish to make no designation at this time.

Signature of Patient /Parent/Guardian

Date

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Summit Medical Group's making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.)

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Signature of Patient /Parent/Guardian

Date

Please Return to Staff Member or Mail to: Summit Medical Group - HIPAA Coordinator , 1 Diamond Hill Rd, Berkeley Heights, NJ 07922



Behavioral Health and Cognitive Therapy Center

908-508-8909

654 Springfield Avenue, Berkeley Heights, NJ 07922

www.summitmedicalgroup.com

Billing and Payments Agreement

- This Agreement requires you to pay for each session you have at the Behavioral Health & Cognitive Therapy Center (BHCTC) at the end of each session.
- If you have insurance, we will bill the insurance company for you, but we will expect you to pay your co-payment and any deductible at the end of each session.
- As a courtesy, we will check with your insurance carrier and will determine to the best of our ability what you will need to pay at each session.
- **However, because behavioral health insurance tends to be complex we can not guarantee that the information provided to us is correct. As a result, you are responsible for determining your insurance and for paying the BHCTC for treatments that it has provided or are not covered by your insurance plan.**
- By signing below you are agreeing that you will pay any outstanding amounts due to the BHCTC. In circumstances of financial hardship, or if we do not accept your insurance, the BHCTC may have you contact Summit Medical Group's business office to arrange for a payment installment plan.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Signature Patient/Parent/Guardian

Print Patient Name



Questions & Answers About Cognitive Therapy

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Robert L. Leahy and Stephen J. Holland

Q: What is cognitive therapy?

A: Cognitive-behavioral therapy is a relatively short-term, focused psychotherapy for a wide range of psychological problems, including depression, anxiety, anger, marital conflict, and fears. The focus of therapy is on how you are thinking (your cognitions), behaving, and communicating today, rather than on your early childhood experiences. Numerous studies have demonstrated that cognitive-behavioral therapy is as effective as medication for depression, anxiety, obsessions, and other fears. Furthermore, because patients learn self-help in therapy, they are often able to maintain their improvement after therapy has been completed.

Q: What should I expect for my first session?

A: When you begin cognitive-behavioral therapy. Your therapist will ask you to fill out several self-report forms to assess a range of symptoms and problems. These forms evaluate depression, anxiety, anger, fears, physical complaints and relationships. The purpose of this evaluation is to gather as much information as you as possible, so that you and your therapist can learn quickly what kinds of problems you do (or do not) have and the extent of your problems.

Q: What should I expect for follow up treatment?

A: You and your therapist will work together to develop a plan of therapy. This might include how often you come; the relevance of medication; your diagnosis; your goals; skill acquisition; needed changes in the way you think, behave and communicate; and other factors. *Because our goal is to treat your problem quickly and get you back into your life, we limit the number of sessions we provide to 12 per year (four months of weekly appointments).*

Q: What are therapy sessions like?

A: During your cognitive-behavioral therapy sessions you and your therapist will set an agenda for each meeting. The agenda might include a review of your experience in the previous session, your homework, or one or two current problems, a review of what

you've accomplished in this session for the next week. The goal is to solve problems, not just complain about them.

Q: What type of homework will I have?

A: If you went to a personal trainer at a health club, you would expect to get guidance on how to exercise when the trainer is not there. The same this is true in cognitive-behavioral therapy. What you learn in therapy is what you practice outside of therapy on your own. Research demonstrates that patients who carry out homework assignments get better faster and stay better longer. Your self-help might include keeping track of your moods, thoughts and behaviors; scheduling activities; developing goals; challenging your negative thoughts; collecting information; changing the way you communicate with others; and other assignments.

Q: Is it true that my problems are due to my childhood experiences?

A: Part of your problems may be due to how your parents, siblings, and peers treated you, but the solution to your problems lie in that you are thinking and doing today. However, with many people we do find it useful at times to review the sources of your problems and help you learn how to change the way you think about them now.

Q: Is it true that my problems can be due to biochemistry?

A: Part of your problems may be due to biochemistry, but many other factors-such as the way you think, behave, and relate, as well as the current and past life events-are important. Using cognitive-behavioral therapy does not rule out the use of medication. For most psychiatric disorders, there is considerable evidence that cognitive-behavioral therapy is as effective as medication. For very serious levels of depression and anxiety, we believe that it may be best to combine medication with therapy. An advantage of cognitive-behavioral therapy is that you also learn ways to solve your problems on your own.

Q: How can I learn more about cognitive-behavioral therapy?

A: Depending on the problems that you want to solve, your therapist can recommend a number of books or other readings for you. We believe that the more you know about yourself, the better off you will be. We hope that you learn to become your own therapist.

Summit Medical Group
Behavioral Health & Cognitive Therapy

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