GPS Guide to Personal Solutions

Intake Form

Demographic Information

First Name: _____
Middle Initial: _____
Last Name: _____
Date of Birth: _____
Social Security Number (Optional): _____
Sex: M F
Marital Status:_____
Address: _____
City:_____
State: _____
Zip Code: _____
Phone Number: _____
Email Address: _____
Referring Physician Name (Optional): _____
Referring Physician Phone Number & NPI (Optional) : _____

Insurance Information

Primary Insurance Company: _____
Subscriber ID # (including letters): _____
Group Number: _____
Secondary Insurance Company: _____
Subscriber ID # (including letters): _____
Group Number: _____
Insurance Policyholder Full Name: _____
Insurance Policyholder Date of Birth: _____
Insurance Policyholder Address: _____
Insurance Policyholder Relationship: Self Spouse Child Other
Insurance Policyholder Social Security Number: _____
Insurance Policyholder Sex: M F

** Note: All information is required.*

Patient Authorization

I authorize the release of any medical and insurance information necessary to process any claim.

Patient Signature: _____ Date: _____
Guardian Signature (if minor): _____ Date: _____
Patient Full Name: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician, if a referral is required by my insurance plan. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: _____ Date: _____
Guardian Signature (if minor): _____ Date: _____
Patient Full Name: _____

** Note: All signatures are required.*

No Show or Late Cancel Appointments

Commercial Insurances
I have been notified that I will be billed $30 for any appointment I do not show up for, or an appointment that I late cancel for (provide less than 24 hours notice).

Medicaid Insurances
I have been notified that I will be taken off my therapist's schedule and not put back on until I talk to that therapist directly. I may not be put back on the schedule immediately, but at the convenience of my therapist's schedule.

Patient Signature: _____ Date: _____
Guardian Signature (if minor): _____ Date: _____
Patient Full Name: _____

** Note: All signatures are required.*

Therapy Intake Form

GPS Guide to Personal Solutions

1. Patient Contact Information

Date ____________________

Patient Name ____________________________ Address ____

Best contact phone number _______________________ Email address _____________________________________

Emergency contact __________________ Relationship _________________ Phone No _______________________

Primary Care Physician____________________________Tel______________________Fax____________________________

Pharmacy______________________________________Phone No ____

2. Date of Birth M O / D A Y / Y E A R

3. Age ____ Years Old

4. Race/Ethnicity (Check one or more):

☐ American Indian/Alaskan Native ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other____________

5. Current marital status (Check one):

☐ Married, living together ☐ Married, not living together ☐ Separated ☐ Widowed ☐ Divorced

☐ Single, never married ☐ Cohabiting with partner

6. If you are married or cohabitating with partner, how long has this been? ____ Years ____ Months

7. Total number of marriages? __________ **How many children do you have?** __________

8. Spouse's/Partner's Name____

9. Who else lives with you? ____

10. How many years of formal education have you completed? ____ Years

11. Highest degree obtained: (Check only one)

☐ High school graduate ☐ G.E.D. ☐ 4-year college degree ☐ M.B.A./M.A./M.S./M.P.H. ☐ M.D.

☐ J.D. ☐ Ph.D ☐ Other_____________________________

12. What best describes your current employment status? (Check one from each category A, B and C)

A. Employment Status

☐ Unemployed, not looking for employment
☐ Unemployed, looking for employment
☐ Full-time employed ☐ Part-time employed
☐ Retired ☐ Self-employed
☐ On welfare ☐ Social security disability

B. Student Status

☐ Part-time
☐ Full-time
☐ Not a student

C. Volunteer Status

☐ Volunteer Part-time
☐ Volunteer Full-time
☐ No Volunteer Work

14. What is your current occupation?____

15. Current Residence

☐ Own house/condo ☐ Retirement Complex/Senior Housing ☐ Renting ☐ Apartment /Condominium

Are you currently seeing a therapist? (Name)_____

Have you ever seen a psychiatrist/psychotherapist before? If yes, please list:_____

Previous history: Have you ever been treated for any of the following (check all that apply):

_____Depression _____ADHD _____Bipolar (Manic/Depressive) Disorder

_____OCD _____Schizophrenia _____Panic Attacks _____Anxiety

_____Drug Problems _____Anorexia/Bulimia _____Binge-eating

_____Alcohol Problems (including AA) _____PTSD (Post Traumatic Stress Discorder) _____ECT treatment

Please list in chronological order all prior psychiatric hospitalizations (if any) below: None

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Please List *all* current medications below (include birth control pills, over the counter medication and herbal remedies – i.e. decongestants, St. John's Wort, etc.)

Name of Medication	Dosage(Mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing physician

Please review the following list of medications. If you have taken any of these medications in the last **48 months**, please complete the appropriate boxes

Brand Name	Generic Name	if yes	How long did you take it?	What dosage did you take? Mg/d	Did it help?	How often In a day? Indicate 1, 2, or 3 times per day	Any side effects
Selective Serotonin Reuptake Inhibitors (SSRIs)							
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Paxil CR	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertaline						
Prozac	Fluoxetine						
Serotonin - Norepinephrine Reuptake Inhibitors (SNRIs)							
Effexor	Venlafaxine						
EffexorXR	Venlafaxine						
Pristiq	Desvenlafaxin						
Cymbalta	Duloxetine						
Other Antidepressants							
Desyrel	Trazadone						
Serzone	Nefazodine						
Wellbutrin XL/SR	Bupropion XL/SR						
Remeron	Mirtazapine						
Serzone	nefazodone						
Tricyclic Antidepressants							
Adapin	Doxepin						
Anafranil	Clomipramine						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
Sinequan	Doxepin						
Surmontil	Trimipramine						
Tofranil	Imipramine						
Vivactil	Protriptyline						
Other Psychotropics (Have you taken any of these?)		***Please circle those you have taken...***					
Abilify	Buprenorphin	Dexedrine	Ambien	Klonopin	Emsam	Provigil	Thorazine
Risperidal	Campral	A dderall	Buspar	Ativan	Nardil	Depakote	Dalmane
Invega	Antabuse	Vyvanse	Restoril	Xanax	Parnate	Lithium	Orap
Geodon	Suboxone	Strattera	Sonata	hydroxyzine	Halcion	Lamictal	Navane
Zyprexa	Naltrexone	Concerta	Buspar	Valium	Niravam	Phentermine	Trilafon
Seroquel	Ambien CR	Dexedrine	Halcion	vistaril	Tranxene	Tegretol	Mobane
Symbyax	Valproic Acid	Focalin	Atarax	Methadone	Cylert	Topamax	Stelazine
Clozapine	Adderall XR	Ritalin	Librium	Synthoid		Mellaril	Haldol
Rozerem	Metadate	Daytrana	Lunesta	Meridia		Loxitane	Prolixin

Medical History: *(please check all that apply to you)*

	Mark v		Mark v		Mark v
High Blood Pressure		Gastrointestinal Problems (ulcers, pancreatits, irritable bowel, colitis)		Viral Illness (herpes, Epstein-Barr, chronic hepatitis)	
Lung Disease		Arthritis or Rheumatoid Problems		Cancer	
Diabetes		Liver Damage or Hepatitis		Genital Problems	
Heart Disease		Other Endocrine/Hormone Problems		Eating Disorder	
Thyroid Disease		Neurological Problems (stroke, brain tumor, nerve damage)		Eye Problems	
Anemia		Gynecological / hysterectomy		Chronic pain	
Asthma		Urinary Tract or Kidney Problems		Fibromyalgia	
Skin Disease		Migraine or Cluster Headaches		HIV Positive or AIDS	
Seizures		Ear/Nose/Throat Problems		Head Injury	
Other (print below)		High Cholesterol		Sleep apnea	

List all prior surgeries and hospitalizations for medical illness:

_____

_____

Are you allergic to any medication or food? If so, please list below:

_____

Family History: Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate indicate paternal or maternal)

	Father	Mother	Brother	Sister	Aunt	Uncle	Children	Grandparent
ADHD								
Alcohol Problems								
Anxiety								
Bi-polar/Manic Depression								
CHI/TBI - Brain Injury								
Depression								
Drug Problems								
Panic Attacks								
Post Traumatic Stress (PTSD)								
Psychiatric Facility Stay								
Schizophrenia								
Suicide Ideation								

Where did you grow up?

_____

Please list family relationships that are strong for you:

_____

How is your relationship with your parents?

_____

How many brother(s) _____ and sister(s)_____ do you have? Including step siblings.

Were your parents married? ____Yes _____No

Did your parents Divorce? ____Yes ____No If so how old were you?_____

Did your parents Remarry? ____Yes ____No If so how old were you?_____

_____

Regarding alcohol, when was your last drink?_____

In the past 30 days, about how many of those days have you had at least one alcoholic drink?_What is the maximum number of drinks you have had in one day in the past month?_____drinks

DUI _____ DWI _____ Public Intoxication _____ Seizures _____ DT's _____

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Age first used	Last used approx date	Age peak use	Rx abuse?	Current use and frequency
Amphetamine or Speed						
Anabolic Steroids						
Benzodiazepines (Xanax, Valium, Ativan Restoril, Librium)						
Caffeine (coffee, tea, colas, iced tea)						
Cigarettes, cigars, or tobacco						
Cocaine						
Diet Pills						
Diuretics						
Ecstasy						
GHB						
Hallucinogens (LSD, mushrooms, Mescaline)						
Heroin						
Inhalants						
IV Drug use						
Laxatives						
Marijuana						
Pain Pills						
PCP or Angel Dust						
Sleeping Pills						
Tranquilizers						
Other:						

Prior Substance Abuse Treatment:

Inpatient ____Outpatient ____Individual Therapy ____Group Therapy_____

Where did you go for the treatment? _____

Dates:_____

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: Never

Approximate date of attempt	How did you attempt (method)?

Are you currently safe where you are living?

Is anyone hurting you?

GPS Guide to Personal Solutions

Consent to Treatment Agreement

Informed Consent Regarding Limitations on Confidential Communications:
I understand that information about my treatment and communications with my therapist may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission, as explained below:
If necessary to protect my safety or the safety of others.
If I am clearly dangerous to myself my therapist may take steps to seek involuntary hospitalization and may also contact members of my family or others.
If I threaten to kill or seriously hurt someone and the therapist believes I may carry out my threat, or if the therapist believes I will attempt to kill or seriously hurt someone, my therapist may:
- tell any reasonably identified victim;
- notify the police; or
- arrange for me to be hospitalized.

If necessary for me to be hospitalized for psychiatric care.
If a judge thinks the therapist has evidence about my ability to provide care or custody in a child custody or adoption case.
In court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption.
If the therapist believes a child, a disabled person, or an elderly person in my care is suffering abuse or neglect.
To provide information regarding my diagnosis, prognosis and course of treatment or for purposes of utilization review or quality assurance to a third party payer.
In a legal proceeding where I introduce my mental or emotional condition.
If I bring an action against the therapist and disclosure is necessary or relevant to a defense.
If necessary to use a collection agency or other process to collect amounts I owe for services.
If a court orders access to my records in a sexual assault or other criminal case. I additionally authorize my therapist to consult professional colleagues if needed to enhance the clinical services I receive.
I have had the opportunity to discuss this informed consent statement with my therapist. I understand its meaning and consent to receiving services based on this understanding.

Client Signature:_____
Date:_____

Therapist
Signature:_____
Date: _____

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 Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to 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 by posting a copy on our website, sending a copy to you in the mail upon request or 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, 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 disclose 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. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel

only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if 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.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also 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 at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

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 at 913 W. Holmes Road Suite 143 Lansing MI 48910:

- **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 is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are 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 or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.**
- **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. If we deny**

your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **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 unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.**
- **Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.**
- **Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.**
- **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 at 517-667-0061or 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.

The effective date of this Notice is September 2013.

Patient/Client Name:_____ **DOB:** _____ **SSN:**_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of [GPS Guide to Personal Solutions]'s Notice of Privacy

Practi nd that if I have any questions regarding the Notice or my privacy rights, I can contact [Nicole Dingwell, LMSW at 517-667-0061].

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

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

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

GPS Guide to Personal Solutions

913 W Holmes Road Suite 143 Lansing, MI 48910

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ Date _____

Signature (Client's Parent/Guardian if under 18)

_____ Date _____

Therapist Signature/Witness Signature

GPS Guide to Personal Solutions Social Media Policy

This document outlines office policies related to use of Social Media. Please read it to understand how GPS representatives and contractors conduct themselves on the Internet as a mental health professionals and how you can expect your therapist to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, we encourage you to bring them up when you meet with your therapist. As new technology develops and the Internet changes, there may be times when GPS needs to update this policy. If we do so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending

GPS representatives and contractors do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of a therapeutic relationship between you and your therapist. If you have questions about this, please bring them up when you meet with your therapist so you can talk more about it.

Following

GPS representatives may publish a blog on their website and/or post therapeutic news on Twitter.
We have no expectation that you as a client will want to follow any of our blog or Twitter streams. However, if you use an easily recognizable name on Twitter and I happen to notice that you've followed GPS or your therapist there, we may briefly discuss it and its potential impact on our working relationship.

Social Media Policy

GPS' primary concern is your privacy. If you share this concern, there are more private ways to follow representatives and/or contractors on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate your having a public link to GPS content. You are welcome to use your own discretion in choosing whether to follow anyone.
Note that GPS' representatives and/or contractors will not follow you back. GPS only follows other health professionals on Twitter and do not follow current or former clients on blogs or Twitter. The reasoning is that we believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with us, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Interacting

Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact GPS. These sites are not secure and GPS may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with GPS in public online if we have an already established client/therapist relationship. Engaging with GPS or your therapist this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.
If you need to contact your therapist or GPS between sessions, the best way to do so is by phone.

Use of Search Engines

It is NOT a regular part of GPS or your therapists' practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with your therapist via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on

your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if we ever resort to such means, we will fully document it and discuss it with you when we next meet.

Business Review Sites

You may find GPS or your therapists psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find GPS or your therapists' listing on any of these sites, please know that the listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with GPS or your therapist about your feelings about our work, there is a good possibility that we may never see it.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with GPS or your therapist wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and our Ethics Code prohibits us from requesting testimonials. But you are more than welcome to tell anyone you wish that GPS and your therapist is your therapist or how you feel about the treatment we provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, GPS and your therapist hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with us, you can always contact the State of Michigan, which oversees licensing, and they will review the services we have provided.

Location-Based Services

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from our office or if you have a passive LBS app enabled on your phone.

Email

We prefer using email only to arrange or modify appointments. Please do not email GPS or your therapist content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with GPS by email, be aware that all emails are retained in the logs of your and GPS or your therapists' internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails we receive from you and any responses that we send to you become a part of your legal record.

Conclusion

Thank you for taking the time to review GPS and your therapists' Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to our attention so that we can discuss them.

Client Signature _____Date_____

Therapist Signature_____Date_____

PARENTAL CONSENT FOR MINOR

Child Name _____

Parental Custody
Who has legal custody or guardianship to make treatment decisions for this child?

_____

_____

_____

_____

If parents are divorced is there _____Joint Legal Custody _____Single Parent

Legal Custody? Or

Other

_____

I give permission for my daughter / son _____
to be seen for therapy at GPS Guide to Personal Solutions.

Signed:_____
Signed:_____
Parent/Guardian Parent/Guardian

Date:_____ Date:_____

OFFICE ONLY ID:_____ Respondent: _____ Times @ Clinic_____ Date:_____
Assessor:_____ Vscale_____ VP1: ❑ Y ❑ N VP2: ❑ Y ❑ N VP3: ❑ Y ❑ N

TRAUMATIC EVENTS SCREENING INVENTORY- PARENT REPORT REVISED

Children may experience stressful events, which may affect their health and well-being. Please indicate *if* your child has experienced any of these potentially stressful events by answering the shaded questions. If the answer is yes, please answer the follow-up questions. If it's no, please go to the next shaded question.

If you have any questions or comments about any of the questions, we would be happy to talk to you about them.

SAMPLE ITEM *(instructions are in italics)*

A. **Has your child ever had a doctor's visit?** *(Mark your answer in the next column. If yes answer the questions below.)* → ❑Yes ❑ No ❑ Unsure

If YES ➪ How old was your child?

The first time:_____ **The last time:_____** **The most stressful:_____**

Your child's age the first time s/he saw a doctor (even if s/he would not have remembered it).

Your child's age during his/her most recent doctor's visit.

Your child's age during the most stressful visit for your child (in your opinion).

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure
(By strongly affected we mean: did your child seem: a) to be extremely frightened; b) to be very confused or helpless; c) to be very shocked or horrified, d) to have difficulty getting back to her or his normal way of behaving or feeling when it was over, OR e) to behave differently in important ways after it was over.)

1.1 Has your child ever ***been in*** a serious accident where someone could have been (or actually was) severely injured or died? (like a serious car or bicycle accident, a fall, a fire, an incident where s/he was burned, an actual or near drowning, or a severe sports injury) → ❑Yes ❑ No ❑ Unsure

If YES ➪ Identify the type of accident(s):_____

Victim's relationship to your child:_____ Did anyone die? ❑ yes ❑ no ❑ unsure

How old was your child? The first time:_____ The last time:_____ The most stressful:_____

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.2 Has your child ever ***seen*** a serious accident where someone could have been (or actually was) severely injured or died? (like a serious car or bicycle accident, a fall, a fire, an incident where someone was burned, an actual or near drowning, or a severe sports injury) → ❑Yes ❑ No ❑ Unsure

If YES ➪ Identify the type of accident(s) _____

Victim's relationship to your child:_____ Did anyone die? ❑ yes ❑ no ❑ unsure

How old was your child? The first time:_____ The last time:_____ The most stressful:_____

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.3 Has your child ever been in a natural disaster where someone could have been (or actually was) severely injured or died, or where your family or people in your community lost or had to permanently leave their home (like a tornado, fire, hurricane, or earthquake)? → ❑Yes ❑ No ❑ Unsure

If YES ➪ Type of disaster:_____ Did anyone die? ❑ yes ❑ no ❑ unsure

How old was your child? The first time:_____ The last time:_____ The most stressful:_____

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.4a Has your child ever experienced the severe illness or injury of someone close to him/her? ⟶ IF YES ➪ What was this person's relationship to your child?_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
1.4b Has your child ever experienced the death of someone close to him/her? ⟶ IF YES ➪ What was this person's relationship to your child?_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was the death(s) due to: *(check all that apply)* ❑ natural causes ❑ illness ❑ accident ❑ violence ❑ unknown Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
1.5 Has your child ever undergone any serious medical procedures or had a life threatening illness? Or been treated by a paramedic, seen in an emergency room, or hospitalized overnight for a medical procedure? ⟶ IF YES➪ Describe _____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
1.6 Has your child ever been separated from you or another person who your child depends on for love or security for more than a few days OR under very stressful circumstances? For example due to foster care, immigration, war, major illness, or hospitalization. ⟶ IF YES➪ Who was your child separated from: _____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
1.7 Has someone close to your child ever attempted suicide or harmed him or herself? ⟶ IF YES ➪ What was this person's relationship to your child?_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
2.1 Has someone ever physically assaulted your child, like hitting, pushing, choking, shaking, biting, or burning? Or punished your child and caused physical injury or bruises. Or attacked your child with a gun, knife, or other weapon? (This could be done by someone in the family or by someone not in your child's family). ⟶ IF YES➪ What was this person's relationship to your child? _____ Was a weapon used? ❑ unsure ❑ no ❑ yes (type)_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure

2.2 Has someone ever directly threatened your child with serious physical harm? →	❑Yes ❑ No ❑ Unsure
IF YES➪ What was this person's relationship to your child? _____ Did they threatened to use a weapon? ❑ unsure ❑ no ❑ yes (type)_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
2.3 Has someone ever mugged or tried to steal from your child? Or has your child been present when a family member, other caregiver, or friend was mugged? →	❑Yes ❑ No ❑ Unsure
IF YES➪ Who was mugged? (If not your child indicate the person's relationship to your child.) _____ Was a weapon used? ❑ unsure ❑ no ❑ yes (type)_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
2.4 Has anyone ever kidnapped your child? (including a parent or relative) Or has anyone ever kidnapped someone close to your child? →	❑Yes ❑ No ❑ Unsure
IF YES➪ Who was kidnapped? (If not your child indicate the person's relationship to your child.) _____ What was the kidnapper's relationship to your child? _____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
2.5 Has your child ever been attacked by a dog or other animal? →	❑Yes ❑ No ❑ Unsure
IF YES➪ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child seriously physically hurt as a result of the attack? ❑yes ❑ no ❑ unsure Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
3.1 Has your child ever seen, heard, or heard about people ***in your family*** physically fighting, hitting, slapping, kicking, or pushing each other. Or shooting with a gun or stabbing, or using any other kind of dangerous weapon? →	❑Yes ❑ No ❑ Unsure
IF YES➪ What were these people's relationships to your child? _____ Was a weapon used? ❑ unsure ❑ no ❑ yes (type)_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Did your child see what happened? ❑yes ❑ no ❑ unsure Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	

3.2 Has your child ever seen or heard people ***in your family*** threaten to seriously harm each other? →	❑Yes ❑ No ❑ Unsure
IF YES➪ What were these people's relationships to your child? _____ Did they threatened to use a weapon? ❑ unsure ❑ no ❑ yes (type)_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child present when the threat was made? ❑yes ❑ no ❑ unsure Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
3.3 Has your child ever known or seen that a family member was arrested, jailed, imprisoned, or taken away (like by police, soldiers, or other authorities)? →	❑Yes ❑ No ❑ Unsure
IF YES➪ What was this person's relationship to your child?_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child there when the police came? ❑yes ❑ no ❑ unsure Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
4.1 Has your child ever seen or heard people ***outside your family*** fighting, hitting, pushing, or attacking each other? Or seen or heard about violence such as beatings, shootings, or muggings that occurred in settings that are important to your child, such as school, your neighborhood, or the neighborhood of someone important to your child? →	❑Yes ❑ No ❑ Unsure
IF YES➪ What were these people's relationship to your child? _____ Was a weapon used? ❑ unsure ❑ no ❑ yes (type)_____ Where did this happen? _____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Did your child see what happened? ❑yes ❑ no ❑ unsure Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
4.2 Has your child ever been directly exposed to war, armed conflict, or terrorism? →	❑Yes ❑ No ❑ Unsure
IF YES➪ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
4.3 Has your child ever seen or heard acts of war or terrorism on the television or radio? →	❑Yes ❑ No ❑ Unsure
IF YES➪ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
5.1 Has someone ever ***made*** your child see or do something sexual (like touching in a sexual way, exposing self or masturbating in front of the child, engaging in sexual intercourse) →	❑Yes ❑ No ❑ Unsure
IF YES➪ What was this person's relationship to your child? _____ Was physical violence used? ❑ unsure ❑ no ❑ yes Was a weapon used? ❑ unsure ❑ no ❑ yes (type)_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	

5.2 Has your child ever been present when someone was being forced to engage in any sort of sexual activity? ⟶ IF YES➪ What were these people's relationship to your child? Victim:_____ Aggressor:_____ Was physical violence used? ❑ unsure ❑ no ❑ yes Was a weapon used? ❑ unsure ❑ no ❑ yes (type)_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
6.1 Has your child ever repeatedly been told s/he was no good, yelled at in a scary way, or had someone threaten to abandon, leave or send him/her away? ⟶ IF YES➪ What was this person's relationship to your child?_____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
6.2 Has your child ever gone through a period when s/he lacked appropriate care (like not having enough to eat or drink, lacking shelter, being left alone when s/he was too young to care for herself/himself, or being left with a caregiver who was abusing drugs) ⟶ IF YES➪ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
7.1 Have there been other stressful things that have happened to your child? ⟶ IF YES➪ Briefly describe these things:_____ _____ How old was your child? The first time:_____ The last time:_____ The most stressful:_____ Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure

CHILD BEHAVIOR CHECKLIST FOR AGES 4-16

For office use only
ID #

CHILD'S NAME

SEX ☐ Boy ☐ Girl

AGE

ETHNIC GROUP OR RACE

TODAY'S DATE

Mo._____ Day_____ Yr._____

CHILD'S BIRTHDATE

Mo._____ Day_____ Yr._____

GRADE IN SCHOOL

PARENT'S TYPE OF WORK *(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant, even if parent does not live with child.)*

FATHER'S TYPE OF WORK:_____

MOTHER'S TYPE OF WORK:_____

THIS FORM FILLED OUT BY:

☐ Mother (name):_____

☐ Father (name):_____

☐ Other—name & relationship to child:_____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

Compared to other children of the same age, about how much time does he/she spend in each?

	Don't Know	Less Than Average	Average	More Than Average
a._____	☐	☐	☐	☐
b._____	☐	☐	☐	☐
c._____	☐	☐	☐	☐

Compared to other children of the same age, how well does he/she do each one?

	Don't Know	Below Average	Average	Above Average
a._____	☐	☐	☐	☐
b._____	☐	☐	☐	☐
c._____	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include T.V.)

☐ None

Compared to other children of the same age, about how much time does he/she spend in each?

	Don't Know	Less Than Average	Average	More Than Average
a._____	☐	☐	☐	☐
b._____	☐	☐	☐	☐
c._____	☐	☐	☐	☐

Compared to other children of the same age, how well does he/she do each one?

	Don't Know	Below Average	Average	Above Average
a._____	☐	☐	☐	☐
b._____	☐	☐	☐	☐
c._____	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

Compared to other children of the same age, how active is he/she in each?

	Don't Know	Less Active	Average	More Active
a._____	☐	☐	☐	☐
b._____	☐	☐	☐	☐
c._____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, etc.

☐ None

Compared to other children of the same age, how well does he/she carry them out?

	Don't Know	Below Average	Average	Above Average
a._____	☐	☐	☐	☐
b._____	☐	☐	☐	☐
c._____	☐	☐	☐	☐

3-81 Edition

V. 1. **About how many close friends does your child have?** ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. **About how many times a week does your child do things with them?** ☐ less than 1 ☐ 1 or 2 ☐ 3 or more

VI. **Compared to other children of his/her age, how well does your child:**

	Worse	About the same	Better
a. Get along with his/her brothers & sisters?	☐	☐	☐
b. Get along with other children?	☐	☐	☐
c. Behave with his/her parents?	☐	☐	☐
d. Play and work by himself/herself?	☐	☐	☐

VII. 1. **Current school performance—for children aged 6 and older:**

☐ Does not go to school

	Failing	Below average	Average	Above average
a. Reading or English	☐	☐	☐	☐
b. Writing	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Spelling	☐	☐	☐	☐
Other academic subjects—for example: history, science, foreign language, geography. e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

2. **Is your child in a special class?**

☐ No ☐ Yes—what kind?

3. **Has your child ever repeated a grade?**

☐ No ☐ Yes—grade and reason

4. **Has your child had any academic or other problems in school?**

☐ No ☐ Yes—please describe

When did these problems start?

Have these problems ended?

☐ No ☐ Yes—when?

VIII. Below is a list of items that describe children. For each item that describes your child **now or within the past 6 months**, please circle the **2** if the item is **very true** or **often true** of your child. Circle the **1** if the item is **somewhat** or **sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Allergy (describe): _____
_____
0 1 2 3. Argues a lot
0 1 2 4. Asthma
0 1 2 5. Behaves like opposite sex
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Day-dreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or other children
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other children
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Eats or drinks things that are not food (describe): _____
_____
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with children who get in trouble
0 1 2 40. Hears things that aren't there (describe):
_____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Likes to be alone
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe):
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other children
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired
0 1 2 55. Overweight
56. Physical problems without known medical cause:
0 1 2 a. Aches or pains
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (describe):
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Please see other side

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____

_____ 80

0 1 2 59. Plays with own sex parts in public 16
0 1 2 60. Plays with own sex parts too much

0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy

0 1 2 63. Prefers playing with older children 20
0 1 2 64. Prefers playing with younger children

0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____

_____

0 1 2 67. Runs away from home
0 1 2 68. Screams a lot 25

0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):

_____

_____

0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires

0 1 2 73. Sexual problems (describe):

_____

_____ 30

0 1 2 74. Showing off or clowning

0 1 2 75. Shy or timid
0 1 2 76. Sleeps less than most children

0 1 2 77. Sleeps more than most children during day and/or night (describe): _____

_____

0 1 2 78. Smears or plays with bowel movements 35

0 1 2 79. Speech problem (describe): _____

_____

0 1 2 80. Stares blankly

0 1 2 81. Steals at home
0 1 2 82. Steals outside the home

0 1 2 83. Stores up things he/she doesn't need (describe):

_____ 40

0 1 2 84. Strange behavior (describe): _____

_____

0 1 2 85. Strange ideas (describe):

_____

0 1 2 86. Stubborn, sullen, or irritable

0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot 45

0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language

0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe):

_____

0 1 2 93. Talks too much 50
0 1 2 94. Teases a lot

0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much

0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking 55

0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Trouble sleeping (describe):

_____

0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy

0 1 2 103. Unhappy, sad, or depressed 60
0 1 2 104. Unusually loud

0 1 2 105. Uses alcohol or drugs (describe):

_____

0 1 2 106. Vandalism

0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed 65

0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex

0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worrying

113. Please write in any problems your child has that were not listed above:

0 1 2 _____ 70

0 1 2 _____

0 1 2 _____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

UNDERLINE ANY YOU ARE CONCERNED ABOUT.

FEE AGREEMENT AND FINANCIAL POLICY

Thank you for choosing GPS Guide to Personal Solutions. Please review this Fee Agreement and Financial Policy (the "Agreement and Policy"), which describes our schedule of fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancelations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, **please ask your provider prior to signing this Agreement and Policy**.

Our service rates and corresponding health insurance billing codes (numbers starting with '90' refer to mental health services) this is not a comprehensive list and reflects the most common services provided by our staff. Additional codes may be used by your provider as deemed appropriate.

- 90791 Initial Consultation – Individual (50-60 min.) $225.00
- 90837 Individual Therapy (60 min.) $150.00
- 90834 Brief Individual Therapy (45 min.) $130.00
- 90853 Groupo Therapy (60 min.) $50.00

ADDITIONAL FEES

- Late cancelations/Missed Appointment – fewer than 24 hrs. prior to appointment $30.00
- Non-sufficient funds (bounced) check $30.00
- Past-due accounts – over 30 days $25.00 per month
- Checks returned due to insufficient funds will incur a fee of $45.00

PAYMENT

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services provided under the ***Outpatient Services Agreement***, which will be given to you along with this Agreement and Policy and our ***Notice of Privacy Practices***. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to GPS Guide to Personal Solutions.

INSURANCE REIMBURSEMENT

GPS accepts and process insurance payments through a variety of insurance providers and Employee assistance plans. If you are using insurance or Employee assistance provider to pay for our services, then we will:

(1) Expect and accept payment of your copayment amount at the time of service;

(2) File your claim with the insurance provider

(3) Receive payment from your insurance provider

Expect that you will pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your

PLEASE NOTE

GPS files insurance as a courtesy to you, and that you (not your insurance company) are ultimately responsible for your bill. If you insurance company denies a claim filed on your behalf, then you are responsible to pay GPS for the difference between the standard rate and the amount previously paid as copay unless approved otherwise by owners of GPS.

I agree to (1) allow GPS to bill my insurance directly for services provided under the Outpatient Services Agreement; (2) give GPSpermission to release any information the insurance company may require in order to process payment; appoint GPS as my authorized representative to act for me in obtaining payment; (3) assign all of my rights to claims and payment by my insurance to GPS; and (4) agree to assist with the claims process as required by TGPS or my insurance provider. I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

Patient name (printed)______

Patient /Guardian signature:______

Private/Self-Payment for Services

I will self-pay for services at GPS. I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

Patient name (printed)______

Patient /Guardian signature:______