# Dr. Wall & Associates

**Counseling | Consultation | Education | Clinical Supervision**
2825 S. Meridian Road, Suite 150 | Meridian, Idaho 83642
208-297-9495 Office | 208-955-2490 Fax

# Welcome

We know how hard it is to meet with a counselor for the first time. We are grateful to be invited to hear part of your story. Listed below are few bits of information we hope will take some of the stress out of your first session.

**What to Bring**

- Photo ID
- Insurance Card
- Copayment or deductible
    - We accept cash, checks, credit cards, and paypal
    - We will be glad to keep a credit card on file if you will not be accompanying your child to sessions.

**A Few Things to Remember About Counseling**

- Individual sessions run between 30 – 50 minutes depending on your insurance.
- Sessions are scheduled every hour. If you arrive late, time cannot be added to the end of the session.
- It is against our professional licensing and ethics to provide telephone sessions. Please make an appointment to discuss your, or your child's, progress and any new information.
- For billing, insurance, or scheduling information please call Dana at 208-297-9495 or email her at dwformistylwallphd@gmail.com.

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# Intake Form

## Client information

| | | | | | |
|---|---|---|---|---|---|
| Client Name | | DOB | | Age | |
| Race | | Ethnicity | | Legal Status | |
| Email Address | | | | SSN | |
| Address | | City | | Zip | |
| Primary Phone<br>☐OK to text messages<br>☐OK to leave message | | Secondary Phone<br>☐OK to text messages<br>☐OK to leave message | | | |
| Emergency Contact | | | | Phone | |

| | | | | |
|---|---|---|---|---|
| Parent/Guardian 1<br>☐ Legal Guardian<br>☐ Not Allowed Contact | Name | | Relationship | |
| | Address | | Phone | |
| | Email | | | |
| Parent/Guardian 2<br>☐ Legal Guardian<br>☐ Not Allowed Contact | Name | | Relationship | |
| | Address | | Phone | |
| | Email | | | |
| How did you hear about us? | | | | |

## Insurance Information

***Please provide a copy of your current insurance card.***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name of Insured (if different than client) | | | | DOB | | SSN | |
| Relationship to Insured | | Employer | | ID | | Group | |

## Educational Information

| | | | | | |
|---|---|---|---|---|---|
| Highest Grade Completed | | Current Grade | | School | |
| Is there an IEP/504 in place? | Yes No Not sure | | Education Concerns | | |

## Employment/Housing Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Current Employer | | | | | Length of Employment | | |
| Do you enjoy your work? | Yes | No | Unsure | Describe your job duties. | | | |
| Are you concerned about money? | Yes | No | Unsure | Do you feel safe in your home? | Yes | No | Unsure |

| List who lives in your home. | Name | Relationship | Age | Concern |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Legal History

| | | | |
|---|---|---|---|
| Have you ever been arrested? | ☐Yes ☐No | Are you currently on probation or parole? | ☐Yes ☐No |
| Have you ever been convicted of a crime? | ☐Yes ☐No | Does an attorney currently represent you? | ☐Yes ☐No |
| Describe current legal concerns | | | |

## Current Medical Information

| | | | | | |
|---|---|---|---|---|---|
| Primary Care Physician (PCP) | | | May we contact your PCP to share records and coordinate care? | ☐ Yes ☐ No | |
| Chronic Medical Conditions | 1. | 2. | 3. | | |
| Overall, I consider myself in good physical health. | Strongly Agree | Agree | Unsure | Disagree | Strongly Disagree |
| Medical Concerns | | | | | |

### Current Medications

| Name | Dosage | Purpose | Prescribing Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Allergies | |
|---|---|

## Current Concerns

*Please circle your answer. Feel free to write in your current concerns if they are not listed.*

| | | | | | |
|---|---|---|---|---|---|
| Anxiety | Lack of motivation | Anger | Grief/loss | Thinking of dying | Mood swings |
| Depression | Flashbacks | Difficulty focusing | Relationship problems | Panic attacks | Cutting or self harm |
| Hallucinations | Gender identity | Sexual orientation | Childhood Trauma | Parenting | Recent Trauma |
| Night terrors | Divorce | Sexual problems | Obsessions | Substance Use | School/work problems |
| Other (list) | | | | | |

## Psychiatric and Trauma History

*Please circle your answer. Provide a short explanation of questions answered "Yes".*

| | | | |
|---|---|---|---|
| Have you ever been diagnosed with a mental health disorder? | Yes No | Have you ever been hospitalized for a mental health incident? | Yes No |
| Have you ever thought about harming yourself? | Yes No | Have you ever harmed yourself? | Yes No |
| Have you ever been abused physically? | Yes No | Have you ever been abused emotionally? | Yes No |
| Have you ever been neglected? | Yes No | Have you ever been abused sexually? | Yes No |
| Have you ever been in a violent relationship? | Yes No | Are you currently in a violent relationship? | Yes No |
| Have you ever had a head injury? | Yes No | Have you experienced any other trauma? | Yes No |
| Are there other events your therapist should be aware? | Yes No | Describe: | |

## Current & History of Personal Treatment

(counseling, medication management, CBRS, PSR, etc.)

| Dates | Provider | Service Provided | Outcome (Completed program, did not like, etc.) | May we contact this provider to share records and coordinate care? |
|---|---|---|---|---|
| | | | | ☐Yes ☐No |
| | | | | ☐Yes ☐No |
| | | | | ☐Yes ☐No |
| | | | | ☐Yes ☐No |
| | | | | ☐Yes ☐No |
| | | | | ☐Yes ☐No |

## Spirituality/Faith

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| What is your current spiritual belief system? | | | | | | | | | | | |
| How important is your current spiritual belief system in your life? (0 being no importance, 10 being the most important thing) | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| What was the spiritual belief system in your family of origin? | | | | | | | | | | | |
| Describe parts of your faith your therapist needs to understand. | | | | | | | | | | | |

## Gender, Gender Identity, Sexual Orientation

*Dr. Wall & Associates does not discriminate on the basis of sexual orientation, gender identity, or expression. We understand that these areas are important aspects of your life and we want to ensure we meet your needs and expectations. These are optional questions, please feel free to not answer for any reason and without question.*

| | | | | |
|---|---|---|---|---|
| Do you consider yourself a member of the (LGBT) community? | ☐ Yes<br>☐ No<br>☐ Prefer not to say | What is your sexual orientation? | ☐ Asexual<br>☐ Straight/Heterosexual<br>☐ Gay or Lesbian<br>☐ Bisexual<br>☐ Asexual | ☐ Pansexual<br>☐ Prefer to self-describe<br>_____<br>☐ Prefer not to say |
| What is your gender identity? | ☐ Agender<br>☐ Cisgender<br>☐ Genderqueer<br>☐ Male<br>☐ Female<br>☐ Trans Man | ☐ Trans Woman<br>☐ Prefer to self-describe _____<br>☐ Prefer not to say | | |
| What is your gender? | ☐ Female<br>☐ Male<br>☐ Non-binary<br>☐ Prefer to self-describe<br>☐ Prefer not to say | Preferred Pronouns | ☐ She/her<br>☐ He/him<br>☐ They/them<br>☐ Prefer to self-describe _____ | |

## Family History

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Depression | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Anxiety | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Bipolar Disorder | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Schizophrenia | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Alcohol Use or Abuse | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Substance Use or Abuse | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Self Harm | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Psychiatric Hospitalizations | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Committed Suicide | | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Suicide Attempts | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Tobacco Use | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Diabetes | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Heart Disease | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| High Blood Pressure | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Other: | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Other: | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Other: | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Other: | Self | Mother | Father | Siblings | Mother's Family | Father's Family | Other |
| Explanation | | | | | | | |

| More About You | |
|---|---|
| What do you consider your most often used coping skill? (i.e. when things are bad what do you do to make it through?) | |
| Describe your strengths. (i.e. what are you good at?) | |
| Describe your support system(s). (i.e. who helps you when needed?) | |
| Describe the most problematic relationships in your life now. | |
| Describe your goals as they relate to therapy. (What do you want to see change or shift in your life?) | |
| Have you ever had a positive or negative relationship with a counselor? Please describe those relationships. | |
| Describe anything else your therapist should know about you or what brought you in today. | |

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# Informed Consent

## My Responsibilities to You as Your Therapist

### Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA).

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

- If the client is evaluated to be a danger to self/others.
- If I am appointed by the court to evaluate and/or provide treatment to you.
- If the client is a minor, elderly, or disabled and the social worker believes he or she is a victim of, or at risk of, abuse, or, if the client divulges information about such abuse/risk of abuse.
- If the client files suit against the social worker for breach of duty.
- If a court order or other legal proceedings or statute requires disclosure of information.
- If the client waives the rights to privilege or gives written consent to disclose information.
- Anonymous disclosures for audits, evaluations, or research without personally identifying information.
- To third party payers (i.e., insurance companies) or those involved in collecting fees for services.
- Disclosures to other professionals or supervisees directly involved in your treatment or diagnosis.

### Record-Keeping

I am required by both the law and the standards of my profession to maintain appropriate treatment records. These may include diagnosis, therapy goals, treatment progression, documentation of mandated disclosures (i.e. report of child abuse), and other information. You have a right to review and/or receive a copy of your records unless in my professional opinion, I find that doing so would be likely to cause you substantial harm, endanger your life or physical safety, or pose a significant risk of harm to another individual. Alternately, I can prepare an appropriate summary of these records. Given their inclusion of professional language, these records may be difficult to interpret or understand. If you wish to review your records, I recommend you review them in my presence so we can discuss their content.

### Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. I will be glad to discuss your diagnosis with you at any time.

### Risks and Benefits

Psychotherapy is a process in which the therapist and client, and sometimes other family members, discuss a myriad of issues, events, symptoms, experiences and memories for the purpose of creating positive change so that the client can experience his or her life more fully.

Therapy provides an opportunity to better and more deeply understand oneself as well as any problems or difficulties the client may be experiencing. Psychotherapy is a joint effort between the client and therapist. Progress and success may vary depending on the particular problems or issues being addressed, as well as many other factors.

Specifically addressing symptoms of obsessive compulsive disorder (OCD) using cognitive-behavioral therapy (CBT) may temporarily increase anxiety; however, many clinicians report that 80 to 90 percent of their clients benefit from treatment using this approach. Participating in therapy may result in a number of benefits to the client, including reduced stress and anxiety, a decrease in negative

thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence.

Such benefits may also require substantial effort on the part of the client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc.

There may be times in which the therapist will challenge the perceptions and assumptions of the client or other family members, and offer different perspectives. The issues presented by the client may result in unintended outcomes, including changes in personal relationships. The client should be aware that any decision on the status of his or her personal relationships is the responsibility of the client.

During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. A client should address with the therapist any concerns he or she has regarding progress in therapy.

**Fees**

Individual therapy is $150 per session, with each session being up to 50 minutes long. Couples therapy is $185 per 50-minute session and your initial assessment is $175. You will be asked to pay for each session at the time of the session. If I am required to attend court or other meetings on your behalf the fee per hour is $150. Check, cash, or credit cards can be used to make payments. If you receive health insurance benefits, please know that I do accept most types of insurances and all co-payments will be due at the time of service. Psychotherapy sessions are scheduled at an ongoing weekly basis, weekly, bi-weekly or monthly basis. **Depending on insurance coverage, sessions usually last between 35 – 50 minutes.**

**Cancelled Appointments & No Shows**

There is a fee of $25 for each session cancelled less than 24 hours in advance and for each no show. After 3 no shows, or cancelations without 24 hours notice, you will be discharged.

**After-Hours Services**

Dr. Wall & Associates does not provide coverage after hours. In the event of a mental health crisis call 911 immediately or going to the nearest emergency room. 24/7 access to mental health is also available by contacting:

| | |
|---|---|
| 24/7 Crisis Line for client of any provider at Dr. Wal & Associates | 208-412-5128 |
| Safe Haven of Boise | 208-327-0504 |
| Idaho Suicide Prevention Hotline | 208-398-HELP (4357) |
| 24/7 Optum Crisis Line | 855-202-0973 |
| Intermountain Hospital | 208-377-8400 |
| Translifeline | 877-565-8860 |
| Treveor Project Lifeline (LGBT) | 866-488-7386 |

**Ending Therapy**

Therapy is an intimate process that goes through several distinct phases. Termination is a significant part of the therapeutic process. I want to make your therapy as successful as possible. For that reason, it works best to find a rhythm and structure to the beginning stages of sessions that meet regularly. If you are thinking about ending therapy for any reason, please share those thoughts with me as soon as possible. If I initiate termination of therapy, it will be because I feel that I am not able to be helpful to you. I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy. You are free to leave therapy at any time.

**Other Rights**

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

## Your Responsibilities as a Therapy Client

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last up to 50 minutes. If you are more than 15 minutes late, we will be unable to meet. If you are late, we will end on time and not run over into the next scheduled session. All cancellations must occur at least 24 hours before the scheduled appointment time. If you cancel your appointment with less than 24 hours notice you will be responsible for the co-payment for that session. Please note that after 3 missed appointment times; your scheduled sessions will no longer be reserved for you.

## Complaints

If at any time you feel that your needs are not being met or you are not getting what you want out of our sessions, please tell me, so we can discuss your needs and adjust your therapy treatment plan. If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please discuss these with me. If you are dissatisfied with the outcome of that discussion, you may send a written complaint to the Idaho Board of Licensing. I can provide you with the appropriate address upon request.

## Client Consent to Psychotherapy

| **I have read this statement, had sufficient time to considered it carefully, ask any clarifying questions necessary to aid my understanding, and now fully understand the spirit and letter of the policies and procedures described here and ensure that all of the information I provided is thorough and accurate to the best of my knowledge. My initials to the left and signature below indicates understanding and intent to comply with these polices and procedures.** | | |
|---|---|---|
| **Client** | **Guardian** | |
| | | I understand the limits and requirements of HIPPA. I have been offered a copy of HIPPA policy and I understand I may request a copy of HIPPA requirements at any time. |
| | | I understand the contents of this informed consent and have had an opportunity to ask questions of my provider. I understand that I can ask questions about my rights and responsibilities at any time. |
| | | I consent and authorize Dr. Wall & Associates, or agents, to provide pertinent information to bill my insurance benefits and other PHI concerning me to release information needed to determine those benefits for related services and I request payment of authorized private insurance benefits for any and all services furnished to me be made to Dr. Wall & Associates, or agents, on my behalf. |
| | | I understand there are risks of not participating in treatment, including hospitalization. |
| | | I understand the risks and benefits of having an animal present during my sessions, including, but not limited to, risk of harm. I understand that I can refuse to have an animal present during sessions at any time. |
| | | I understand certain services provided at this office may not be covered by my insurance. I have elected to proceed and have those services provided to me by this office with full knowledge and understanding that any charges incurred including, but not limited to, telephone contacts, documentation, no-shows, rescheduling, court testimony, among others are my responsibility regardless of the insurance coverage. |
| | | I understand that Dr. Wall & Associates, and agents will use the above information to contact me as necessary. I understand that electronic and written communication via text, phone, USPS, voicemail, and email may be compromised despite efforts of Dr. Wall & Associates to adhere to ethical and privacy guidelines; therein making it impossible to unconditionally maintain confidentiality. I am in agreement to receive communication via text, email, USPS, and phone despite these potential limitations to my privacy. |
| | | I understand that no person from Dr. Wall & Associates will use social media to communicate, friend, follow, or otherwise gain information about me. |
| | | I understand the limits to confidentially including, but not limited to, risk of harm to others and myself and child maltreatment. |

| | | | |
|---|---|---|---|
| Client<br>**if 12 and older* | | Date | |
| Parent/Guardian | | Date | |
| ☐ Jennifer A. Kopec, LCSW<br>☐ Caroline Drummond, LCSW<br>☐ | | Date | |
| Misty L. Wall, PhD, MSSW, LCSW<br>Registered Clinical Supervisor | | Date | |

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# Release of Information

| Client | | DOB | |
|---|---|---|---|

I hereby authorize **Dr. Wall & Associates and agents** to use and or disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that the person or entity receiving my PHI, may re-disclose my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such disclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

**I authorize Dr. Wall & Associates, and agents, to** ☐ **release (give) information** ☐ **obtain (get) information** **To/From**

| Name | | **Relationship** | |
|---|---|---|---|
| Phone | | Fax | |

**Category of PHI**

| | | |
|---|---|---|
| ☐ Appointment Schedule | ☐ Recommendations | ☐ Other (list) |
| ☐ Claims/Billing Information | ☐ Summary of Treatment | |
| ☐ Diagnosis | ☐ Treatment Plans | |

**Time of PHI**

☐ Anytime
☐ Between _____ and _____
☐ One year of signature

**Limit of PHI**
***Do Not Include Information Concerning***

| | | |
|---|---|---|
| ☐ HIV/AIDS | ☐ Substance Abuse | ☐ Other |

**Purpose of PHI**

| | |
|---|---|
| ☐ Continuity of services | ☐ Referral |
| ☐ Family Involvement | ☐ Service coordination |
| ☐ Fulfill court orders | ☐ Other (list) |

I understand that I may revoke this authorization at any time through dated, written communication. I also understand that I may not retroactively revoke my permission. I understand that I have the right to withhold my consent.

| | | | |
|---|---|---|---|
| Client<br>**if 12 and older* | | Date | |
| Parent/Guardian | | Date | |
| ☐ Jennifer A. Kopec, LCSW<br>☐ Caroline Drummond, LCSW<br>☐ | | Date | |
| Misty L. Wall, PhD, MSSW, LCSW<br>Registered Clinical Supervisor | | Date | |

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| **I authorize Dr. Wall & Associates, and agents, to** | ☐ **release (give) information**<br>☐ **obtain (get) information** | **To/From** |
|---|---|---|

| Name | | **Relationship** | |
|---|---|---|---|
| Phone | | Fax | |

**Category of PHI**

| | | |
|---|---|---|
| ☐ Appointment Schedule | ☐ Recommendations | ☐ Other (list) |
| ☐ Claims/Billing Information | ☐ Summary of Treatment | |
| ☐ Diagnosis | ☐ Treatment Plans | |

**Time of PHI**

☐ Anytime
☐ Between _____ and _____
☐ One year of signature

**Limit of PHI**
***Do Not Include Information Concerning***

| | | |
|---|---|---|
| ☐ HIV/AIDS | ☐ Substance Abuse | ☐ Other |

**Purpose of PHI**

| | |
|---|---|
| ☐ Continuity of services | ☐ Referral |
| ☐ Family Involvement | ☐ Service coordination |
| ☐ Fulfill court orders | ☐ Other (list) |

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| | | | |
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| Client<br>**if 12 and older* | | Date | |
| Parent/Guardian | | Date | |
| ☐ Jennifer A. Kopec, LCSW<br>☐ Caroline Drummond, LCSW<br>☐ | | Date | |
| Misty L. Wall, PhD, MSSW, LCSW<br>Registered Clinical Supervisor | | Date | |

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# Notice of Privacy Practices

Active April 14, 2003

THIS NOTICE DESCRIBES HOW COUNSELING INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that counseling information about you and your health is personal. We are required by law to maintain the privacy of your health information, to follow the terms of this notice, and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are required to follow the terms of the notice that is currently in effect.

**How Your Counselor May Use Or Disclose Your Health Information**

Your counselor protects the privacy of your health information. For some activities, we must have your written authorization to use or disclose your health information. However, the law permits us to use or disclose your health information for the following purposes without your authorization:

- For Treatment. Information obtained by the Clinic will be used to dispense prescriptions to you. We may disclose health information about you to pharmacists and other persons who are involved in your health care.
- For Payment. We may use and disclose your health information so that our services may be billed to, and payment may be collected from, you, an insurance company or a third party.
- For Health Care Operations. We may use and disclose health information about you for clinical operations. Unless you provide us with alternative instructions, we may send visit reminders and other materials related to your health care to your home. These uses and disclosures are necessary to run the Clinic and make sure that you receive quality customer service.
- As Required by Law. We will disclose health information about you when required to do so by federal, state, or local law.
- To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following: 1)to prevent or control disease, injury, or disability 2)to report reactions to medications or problems with products 3) to notify people of recalls of products they may be using 4) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, and 5) to notify the appropriate government authority if we believe a person has been the victim of abuse, neglect or domestic violence (we will only make this disclosure if you agree and when required or authorized by law).
- For Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include audits, investigations, inspections, and licensure.
- Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court order or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you), or to obtain an order protecting the information requested.
- For Specific Government Functions. Your counselor may disclose health information for the following specific government functions: 1)health information of military personnel, as required by military command authorities 2)health information of inmates, to a correctional institution or law enforcement
- official 3)in response to a request from law enforcement, if certain conditions are satisfied, and 4) for national security reasons.

**Your Counselor May Not Use Or Disclose Your Health Information**

Except as described in this notice, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**You Have The Following Rights With Respect To Your Health Information**

- To request restrictions on certain uses and disclosures of your health information. Your counselor is not required to agree to a restriction that you request. If we do agree to any restriction, we will put the agreement in writing and follow it, except in emergency situations. We cannot agree to limit the uses or disclosures of information that are required by law.
- To inspect and copy your health information as long as the clinic maintains the health information. Your health information usually will include treatment and billing records. To inspect or copy your health information, you must submit a written request to the office that provided your services. We may charge a fee for the costs of copying, mailing or other supplies that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. You have a right to choose to obtain a summary instead of a copy of your health information.
- To request that we amend your health information that is incorrect or incomplete. To request an amendment, you must submit a written request (form available from your clinic), along with the reason for the request. Your counselor is not required to amend health information that is accurate and complete.
- To request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about health matters only in writing or at a different residence or post office box. To request confidential communication of your health information, you must submit a written request. Your request must state how or when you would like to be contacted.

**Changes To This Notice Of Privacy Practices**

Your counselor reserves the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. Any revised notice will be posted in the clinic. Upon request, we will provide a revised notice to you.

**For More Information Or To Report A Problem**

If you have questions or would like additional information about our privacy practices, you may contact the Secretary of Health and Human Services. If you believe your privacy rights have been violated, you can contact the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

# WHODAS 2.0

**W**ORLD **H**EALTH **O**RGANIZATION
**D**ISABILITY **A**SSESSMENT **S**CHEDULE 2.0

## 12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

| In the past 30 days, how much difficulty did you have in: | | | | | | |
|---|---|---|---|---|---|---|
| S1 | Standing for long periods such as 30 minutes? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S2 | Taking care of your household responsibilities? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S3 | Learning a new task, for example, learning how to get to a new place? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S4 | How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S5 | How much have you been emotionally affected by your health problems? | None | Mild | Moderate | Severe | Extreme or cannot do |

| In the past 30 days, how much difficulty did you have in: | | | | | | |
|---|---|---|---|---|---|---|
| S6 | Concentrating on doing something for ten minutes? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S7 | Walking a long distance such as a kilometre [or equivalent]? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S8 | Washing your whole body? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S9 | Getting dressed? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S10 | Dealing with people you do not know? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S11 | Maintaining a friendship? | None | Mild | Moderate | Severe | Extreme or cannot do |
| S12 | Your day-to-day work? | None | Mild | Moderate | Severe | Extreme or cannot do |

| | | |
|---|---|---|
| H1 | Overall, in the past 30 days, how many days were these difficulties present? | ***Record number of days*** _____ |
| H2 | In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition? | ***Record number of days*** _____ |
| H3 | In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition? | ***Record number of days*** _____ |

This completes the questionnaire. Thank you.

*Dr. Wall & Associates*

**Counseling | Consultation | Education | Clinical Supervision**
2825 S. Meridian Road, Suite 150 | Meridian, Idaho 83642
208-297-9495 Office | 208-955-2490 Fax

# PHQ-9

| Client | | Date | |
|---|---|---|---|

Over the past 2 weeks how often have you been bothered by the following problems?

| | Not At All | Several Days | Over Half Of The Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself – or that you are a failure r have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. 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 | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| Column Score | | | | |
| Total Score | | | | |

If you checked off any problems, how difficult have these made it for you to do your work or school, take care of things at home, or get along with other people?

☐ Not Difficult ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

*Dr. Wall & Associates*

**Counseling | Consultation | Education | Clinical Supervision**
2825 S. Meridian Road, Suite 150 | Meridian, Idaho 83642
208-297-9495 Office | 208-955-2490 Fax

# GAD-7

| Client | | Date | |
|---|---|---|---|

Over the past 2 weeks how often have you been bothered by the following problems?

| | Not At All | Several Days | Over Half Of The Days | Nearly Every Day |
|---|---|---|---|---|
| 10. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 11. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 12. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 13. Having trouble relaxing | 0 | 1 | 2 | 3 |
| 14. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 15. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 16. Feeling afraid something awful might happen | 0 | 1 | 2 | 3 |
| Column Score | | | | |
| Total Score | | | | |

If you checked off any problems, how difficult have these made it for you to do your work or school, take care of things at home, or get along with other people?

☐ Not Difficult ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Spitzer, RL; Kroenke, L; Williams; JBW & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine* (166), pp. 1092-1097.