SUMMIT MEDICAL GROUP

Behavioral Health & Cognitive Therapy Center

New Patient Checklist (18 and older)

To ensure a speedy check-in process at our center please be sure to complete the following:

- ☐ Signed Patient-Therapist Agreement (Signatures required on pages 6, 7, & 8)
- ☐ Supplemental Intake Questionnaire
- ☐ Assessments
  - Patient Health Questionnaire
  - Mood Disorder Questionnaire
- ☐ Designation Form (HIPAA)

****Please be sure to verify Mental Health Outpatient coverage with your health insurance company PRIOR to your initial appointment**

****Please give <u>24 hour</u> notice to cancel your appointment to avoid the <u>$100 cancelation fee</u>**

SUMMIT MEDICAL GROUP
Behavioral Health & Cognitive Therapy Center

Office Information and Patient-Therapist Agreement

Signatures Required on Pages 6-8

Welcome to Summit Medical Group's Behavioral Health and Cognitive Therapy Center (BHCTC). We thank you for choosing us for your counseling needs. This Office Information and Patient-Therapist Agreement ("Agreement") includes important information about BHCTC's services, office policies, and expectations.

It is important that you read this Agreement carefully and raise any questions you may have about it with your clinician during your meeting together. By signing this agreement, you acknowledge an understanding of the terms outlined and are aware that both you and your clinician are expected to uphold the terms of this agreement.

You may revoke this Agreement in writing at any time; however, you may still be held to the Agreement's payment obligation. Once you feel all your questions have been answered in terms that are clear to you, if you wish to proceed, please sign the bottom and return this form to the receptionist.

Counseling and Psychotherapy Services

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

Sessions

The first session with your clinician will involve an evaluation of what issues and feelings appear most severe and what treatment methods are needed to address them. By the end of the first evaluation, your clinician will share his/her thoughts on your work together and what treatment they feel will be most helpful. The first session will determine if your clinician and the BHCTC is right for your treatment and will help you to determine if you feel comfortable receiving treatment at the BHCTC.

If you and your clinician choose to begin treatment together, you will be scheduled for treatment sessions at a length and frequency determined by you and you clinician. ***The goal of treatment is to get you feeling and functioning as efficiently as possible and we therefore limit the total number of sessions to 10 for Adults and 15 for Pediatrics***. (For a better understanding of BHCTC's approach please read the "What is Cognitive Behavioral Therapy" handout in this packet).

Your clinician will discuss the possibility of Telepsychiatry sessions with you, if deemed appropriate by the provider, and once the patient therapist relationship has been established, you may be able to begin videoconference session. Telepsychiatry allows for sessions to be held using a secure interactive audio

and video electronic system. This type of session allows for more flexibility in scheduling and provides the convenience of conducting sessions in the comfort of your own home. You must have access to a computer with a webcam and internet access in order to conduct Telepsychiatry sessions. If you and your provider decide to conduct Telepsychiatry sessions, you will receive information on the required software program and logging in.

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

We try very hard to accommodate our patients and to see them in a timely manner; however, there is often a waiting list for individuals seeking treatment due to a lack of available session times. Therefore, if you miss 4 appointments where you fail to give 24 hours cancellation notice or cancel 5 appointments within any 12-month period, even if appropriate notice has been given, you may be subject to dismissal from BHCTC. If you are dismissed, you are only eligible to reapply for treatment after 12-months has passed from the date of your dismissal.

If you miss an appointment without contacting us, we will call and leave you a message about your missed appointment and ask you to call us back within 24hrs. If we do not hear from you within this time frame, we will cancel any remaining appointments you have with us. You may contact us to reschedule if you are eligible to return to the center to continue your treatment.

Working with your Physician

Many of our patients have been referred to us by their Summit Medical Group (SMG) physicians and/or other physicians not affiliated with SMG. We find that contacting these physicians about your treatment ensures that your overall care is uniform and effective. It is our position that notifying your treating physician about the treatment BHCTC is providing to you, and having your physician give us background about your medical history, improves your overall treatment. If your physician is an SMG provider, by signing this, you are authorizing and permitting the BHCTC to contact your physician by the method determined by BHCTC (e.g., phone, letter) and understand that you medical providers have access to your behavioral health information through SMG's electronic medical record.

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

Medication Appointments

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

Professional Fees

The BHCTC's initial psychotherapy intake assessment fee is $288 and $320 for the intake assessment for medication management. The standard 45-minute follow-up psychotherapy session fee is $192, and the standard 20-min f/u medication management fee is $274-$352. We also charge the $192 fee (or break down of the hourly cost for periods of less than 45 minutes) for other services including report writing, attending authorized meetings with other professionals, preparation of records or treatment summaries, telephone conversations lasting longer that 15 minutes, and time spent in any other service you request of us. This fee for non-session services may or may not be reimbursed by your insurance company. If you become involved in any legal proceedings that require our participation, you will be required to pay for our professional time even if we are called to testify by another party. Because of the time-consuming nature of legal involvement, we charge $600 per hour for preparation and attendance at any legal proceeding. These services are usually not reimbursed by your insurance company.

Billing and Payments

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

Insurance Reimbursement

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

Many managed care plans limit counseling and therapy services to short-term treatment designed to work out specific problems that prevent people from living and working as they normally do. As this is the BHCTC's model of treatment, this often works out well. Where necessary, we may request more sessions from the managed care plan. In order to do so, we are typically required to complete the

insurance company's forms which may include providing your diagnosis, the reasons you have sought treatment from the BHCTC, the symptoms you are suffering, and how long we believe treatment will or should continue. The information provided will become part of the insurance company's files. Insurance companies are obligated to keep this information confidential; however, please note that the BHCTC has no control over the handling of this information by the insurance company.

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

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

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

Contacting Us

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

Electronic Communication:

E-mail and/or texting is not completely secure or confidential, therefore we cannot communicate with our patients or former patients via e-mail or texts. For the same reasons, we are unable to accept friend requests from patients (past or present) or communicate in any way via Facebook or Twitter. If you need to speak with your therapist between sessions, the best way to contact him or her is by leaving a message via phone with our front desk staff. They can get any pertinent information to the therapists in a timely fashion.

Professional Records

HIPAA requires that we maintain the confidentiality of "Protected Health Information" (PHI). You are permitted to examine or request a copy of your clinical record upon submitting a written request to do so in accordance with HIAA. Please note that there are some exceptions to release of these records and we will promptly advise you if we are unable to release these records to you upon receipt of your signed

authorization. As behavioral health records may be misinterpreted and/or cause undue stress to patients, we strongly encourage you to initially review them in your clinician's presence or have them forwarded to another mental health professional so you can discuss the contents with that professional. We charge a copying fee for these records, as is permitted by New Jersey regulation.

Patient Rights

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

Minors

If you are under 18 years of age, please be aware that the law provides your parents with the right to examine your treatment records, with certain exceptions. Specifically, New Jersey law provides that where a minor patient is between the age of 14 and 18, treatment records by a licensed psychologist or a social worker may only be released where both the patient and the patient's parent or legal guardian has signed an authorization. A parent or legal guardian of a minor patient treated by a licensed psychologist or social worker who is under the age of 14 may access medical records without the minor patient's authorization. Furthermore, the law allows teenagers 16 and over to consent to "temporary" treatment without parents.

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

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

Confidentiality

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

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

- If we have reasonable cause to believe that a child has been subject to abuse, we must report it to the Division of Youth and Family Services. Once such a report is filed, we may be required to provide additional information.

- If we have reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation, and we believe that the disclosure is necessary to prevent serious harm to that adult or other potential victims, we will report the information to the county adult protective service provider. Once such report is filed, we may be required to provide additional information.

- If a patient communicates a threat, or if we believe the patient presents a threat of imminent serious physical violence against a readily identifiable individual, we may be required to make protective actions. These actions may include notifying the potential victim, contacting the police, or seek the patient's hospitalization.

- If we believe a patient presents a threat of imminent serious physical harm to him/herself, we may take various protective actions. This may include notifying the police of the imminent risk who may then perform a check to determine if the patient holds a gun permit or owns any firearms. If they do the police may remove these firearms from the patient's possession who may then request their return after the threat has subsided.

Clinician Supervision

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

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

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

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

_____ _____

Print Patient Name **Date**

_____ _____

Signature Patient/Parent/Guardian **Signature of Patient (Age 14-17)**

Behavioral Health & Cognitive Therapy Center
908-277-8900
www.summitmedicalgroup.com

Billing and Payments Agreement

- This Agreement requires you to pay for each session you have at the Behavioral Health & Cognitive Therapy Center (BHCTC) by the end of each session.
- If you have insurance, we will bill the insurance company for you, but we will expect you to pay your co-payment and any deductible by the end of each session.
- **Because behavioral health insurance tends to be complex, you are responsible for determining your insurance coverage and for paying the BHCTC for treatments that it has provided or are not covered by your insurance plan.**
- By signing below, you are agreeing that you will pay any outstanding amounts due to the BHCTC. In circumstances of financial hardship, or if we do not accept your insurance, the BHCTC may have you contact Summit Medical Group's business office to arrange for a payment installment plan.

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

_____ _____

Print Patient Name **Date**

_____ _____

Signature Patient/Parent/Guardian **Signature of Patient (Age 14-17)**

Behavioral Health & Cognitive Therapy Center
908-277-8900
www.summitmedicalgroup.com

PATIENT NOTICE OF CANCELLATION POLICY

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

I. What This Is

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

II. Our Policy

We require patients to keep all scheduled appointments. If you must cancel an appointment you must do so **24 hours prior** to the appointment time. If you do not cancel **prior to 24 hours,** the BHCTC will charge for that session. Additionally, if you cancel 5 appointments within a year from the start of treatment, **you may** be subject to dismissal from the BHCTC. **Please note that the automated appointment reminder phone calls are a courtesy only and do not represent a valid excuse for a missed appointment.**

III. Why do we have this policy?

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

IV. What if I have an emergency?

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

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

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

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

_____ _____

Print Patient Name **Date**

_____ _____

Signature Patient/Parent/Guardian **Signature of Patient (Age 14-17)**

SUMMIT MEDICAL GROUP

DESIGNATION OF CERTAIN RELATIVES, FRIENDS, AND/OR OTHER CAREGIVERS

Patient Name: _____ Date: _____

MRN: _____ Date of Birth: _____

I agree that Summit Medical Group (SMG) may disclose certain portions of my health information to a relative, friend, and/or other caregiver because such person is involved with my health care or payment relating to my health care. In that instance, SMG will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

☐ I wish to make no designation at this time.

Signature of Patient/Parent/Guardian: _____

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

Print Name: _____ DOB or Password*: _____

Print Name: _____ DOB or Password*: _____

Print Name: _____ DOB or Password*: _____

***Please list the 4 digit (month & day) date of birth (DOB) of the person listed or choose a password. Please note: The person will have to give his/her DOB or password in order to receive any information.*

Third Party Portal Access

If I am registered to use the SMG Patient Portal, I understand and agree that the following persons will be granted third party access to the portal, which will allow the individual to view all of my protected health information that is available on the portal.

☐ I wish to make no designation at this time.

Print Name: _____ Email Address: _____

Signature of Patient/Parent/Guardian: _____

Please return to your SMG Physician Office or Mail to: HIMS Manager – 150 Floral Avenue, New Providence, NJ 07974

Patient Name: _____

SUMMIT MEDICAL GROUP
Behavioral Health & Cognitive Therapy Center

Adult Supplemental Intake Questionnaire

Please write or circle your responses:

Who referred you to the Behavioral Health and Cognitive Therapy Center? (Both first and last name if known)

_____

Are you currently employed? No Yes If yes, is it: Full Time Part Time

Employer _____ Type of work? _____

If you have a Summit Medical Group doctor, please list _____

Allergies: _____

Current medications with dosage: _____

Please list any current medical conditions: _____

Please list any serious past medical conditions: _____

What is your highest level of education, and where/what did you study? _____

Are you a (circle one): current smoker former smoker never was a smoker

If you do/did smoke, for how many years? _____ How many packs per week? _____

Are you: Single Married In a Domestic Partnership Separated Divorced Widowed Remarried

Who lives in your household? _____

Please list all family members. Include age, gender, occupation, and any serious past or present mental health, substance abuse, or medical problems:

MOTHER	**FATHER**
SIBLING	**SIBLING**
SIBLING	**SIBLING**
CHILD	**CHILD**
CHILD	**CHILD**

PATIENT HEALTH QUESTIONNAIRE™ (PHQ)

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

Name _____ Age_____ Sex: ☐ Female ☐ Male Today's Date: _____

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

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

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

3. Questions about anxiety.

		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack-suddenly feeling fear or panic?	☐	☐
	If you checked "No," go to question 5.		
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue-that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. Think about your last bad anxiety attack.

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

	5. Over the last 4 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things	☐	☐	☐
	If you checked "Not at all," go to question 6.			
b.	Feeling restless so that it is hard to sit still	☐	☐	☐
c.	Getting tired very easily	☐	☐	☐
d.	Muscle tension, aches, or soreness	☐	☐	☐
e.	Trouble falling asleep or staying asleep	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching television	☐	☐	☐
g.	Becoming easily annoyed or irritated	☐	☐	☐

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

6. Questions about eating.

		NO	YES
a.	Do you often feel that you can't control what or how much you eat?	☐	☐
b.	Do you often eat, within any 2-hour period, that most people would regard as an unusually large amount of food?	☐	☐

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

c.	Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?

		NO	YES
a.	Made yourself vomit	☐	☐
b.	Taken more than twice the recommended dose of laxatives	☐	☐
c.	Fasted (not eaten anything at all for at least 24 hours)	☐	☐
d.	Exercised for more than an hour, specifically to avoid gaining weight after binge eating	☐	☐

8. If you checked "Yes" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week? NO ☐ YES ☐

9. Do you ever drink alcohol (including beer or wine)? NO ☐ YES ☐

If you checked "Not at all," go to question 11.

10. Have any of the following happened to you <u>more than once in the last 6 months</u>?

		NO	YES
a.	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health	☐	☐
b.	You drank alcohol, were high from alcohol, or were hung over while you were working, going to school, or taking care of children or other responsibilities	☐	☐
c.	You missed or were late for work, school, or other activities because you were drinking or hung over	☐	☐
d.	You had a problem getting along with other people while you were drinking	☐	☐
e.	You drove a car after having several drinks or after drinking too much	☐	☐

11. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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

12. **In the last 4 weeks, how much have you been bothered by any of the following problems?**	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Worrying about your health	☐	☐	☐
b. Your weight or how you look	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐
d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e. The stress of taking care of children, parents, or other family members	☐	☐	☐
f. Stress at work, outside of the home, or at school	☐	☐	☐
g. Financial problems or worries	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you in the past – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

	NO	YES
13. In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?	☐	☐

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

_____

	NO	YES
15. Are you taking any medication for anxiety, depression, or stress?	☐	☐

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

a. Which best describes your menstrual periods?

Periods are unchanged	**No periods because pregnant or recently gave birth**	**Periods have become irregular or changed in frequency, duration or amount**	**No periods for at least a year**	**Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive**
☐	☐	☐	☐	☐

	No (or N/A)	Yes
b. During the week before your period starts, do you have a serious problem with your mood – like depression, anxiety, irritability, anger or mood swings?	☐	☐
If YES: Do these problems go away by the end of your period?	☐	☐
Have you given birth within the last 6 months?	☐	☐
Have you had a miscarriage within the last 6 month?	☐	☐
Are you having difficulty getting pregnant?	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr. Spitzer at rls8@columbia.edu. The names PRIME-MD® and PRIME-MD TODAY® are trademarks of Pfizer Inc.

Name _____ Today's Date: _____

GAD7

	Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1.	Feeling nervous, anxious or on edge	☐	☐	☐	☐
2.	Not being able to stop or control worrying	☐	☐	☐	☐
3.	Worrying too much about different things	☐	☐	☐	☐
4.	Trouble relaxing	☐	☐	☐	☐
5.	Being so restless that it is hard to sit still	☐	☐	☐	☐
6.	Becoming easily annoyed or irritable	☐	☐	☐	☐
7.	Feeling afraid as if something awful might happen	☐	☐	☐	☐

The Mood Disorder Questionnaire

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

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

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

Versión en español en el reverso

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SUMMIT MEDICAL GROUP
Behavioral Health & Cognitive Therapy Center

Questions & Answers About Cognitive Therapy

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Robert L. Leahy and Stephen J. Holland

Q: What is cognitive therapy?

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

Q: What should I expect for my first session?

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

Q: What should I expect for follow up treatment?

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

Q: What are therapy sessions like?

A: During your cognitive-behavioral therapy sessions you and your therapist will set an agenda for each meeting. The agenda might include a review of your experience in the

previous session, your homework, or one or two current problems, a review of what you've accomplished in this session for the next week. The goal is to solve problems, not just complain about them.

Q: What type of homework will I have?

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

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

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

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

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

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

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