Today's Date

PATIENT INFORMATION-ADULT

Patient's Name _____ Date of Birth _____
Last First M.I.

Home Address _____
Street City State Zip Code

Appointment reminders are sent via email. Print email address(es) for reminders and other health care info.

Email _____ Email _____

Phone (Home / Mobile / Work / Other) _____ Phone (Home / Mobile / Work / Other) _____

Phone (Home / Mobile / Work / Other) _____ Phone (Home / Mobile / Work / Other) _____

Assigned Sex at Birth M F Gender Identification Marital Status Single Married Partnered Separated Divorced Widowed

Race African American Asian Caucasian Hispanic Native American Other _____

Employer _____ Occupation _____

Work Address _____
Street City State Zip Code

Person to notify in case of emergency _____ Relationship to patient _____

Address _____ Phone _____
Street City State Zip Code

REFERRED BY _____

GUARANTOR INFORMATION (where statement will be sent, ***if different from above***)

Initial _____

I understand the guarantor will receive an Encounter Form containing dates of service, appointment codes, and diagnosis. The Encounter Form will have all the information to file with your insurance. You will need to obtain the specific insurance from your insurance provider. Be sure to mark correctly that you are to receive any payments.

Name _____ Relationship to patient _____

Address _____
Street City State Zip Code

Home Phone _____ Work Phone _____

Email _____ Email _____

GENERAL CONSENT FOR TREATMENT: I authorize and request that Dr. Sheinberg carry out diagnostic procedures, psychological exams, and therapeutic treatment, which may be required at the time or during my treatment. I understand that the purpose of these procedures and recommendations will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, Dr. Sheinberg can make no guarantees about the outcome of my treatment. Furthermore, this process may bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand this is a normal response to feeling better, and Dr. Sheinberg will help me work through these. The success of our work together depends on the quality of the efforts on both parts and the realization that I am responsible for lifestyle choices/changes that may result from therapy; specifically, one risk of marital therapy is the possibility of exercising the divorce option.

I am aware that I may stop my treatment with Dr. Sheinberg at any time. **(See section on termination)** I understand that I will still be responsible for paying for the services I have already received. I understand that I may lose other services or have to deal with different problems if I stop treatment (For example, if my treatment has been court-ordered, I will have to answer to the court).

_____ _____

Signature of Patient **Date**

CONDITIONS OF SERVICES

Initial **AUTHORIZATION TO RELEASE INFORMATION**: I authorize the release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for diagnosis, treatment, consultation, and professional communication where appropriate and only when specified by a signed release of information form (see attached forms).

Initial **AUTHORIZATION TO RELEASE INFORMATION TO THE INSURANCE COMPANY**: I authorize the release of information to the assigned insurance company for claims, certification, case management, quality improvement, benefits administration, and other purposes related to my health plan.

Initial **ASSIGNMENT OF INSURANCE BENEFITS**: Dr. Sheinberg is not on any insurance panels and does not accept the assignment of insurance benefits. This helps focus more on direct clinical care. Dr. Sheinberg is classified as an "Out-of-Network" provider regarding insurance. I can request documentation ("an Encounter Form" or Superbill) to seek reimbursement from my insurance provider for Out-of-Network services. All information the insurance company needs is on the "Encounter Form."

FINANCIAL AGREEMENT, CO-PAYMENTS, AND OFFICE POLICIES

Initial I will provide a credit card and HSA card (if applicable) available to photocopy for Dr. Sheinberg's records that will be charged at the time of my appointment or if I do not cancel within 48 hours. I understand that my charges are my responsibility.

Initial I will immediately notify Dr. Sheinberg or the office staff of any changes in my address, phone numbers, email, and payment information.

Initial I understand that I am responsible for obtaining prior authorization for treatment from my insurance carrier if necessary. If I have yet to do so before treatment is rendered, I am aware that my insurance may not reimburse me.

Initial If I choose to file for my insurance benefits, I must verify and obtain authorization for services unless otherwise specified. If my insurance benefits are managed by a managed care organization (MCO), they can refuse to allow Dr. Sheinberg to treat me. The MCO can refuse to pay for any of my treatments or may pay only a tiny part of its cost. Furthermore, it can limit the kinds of treatments provided to me. Even if the MCO gives the go-ahead, I understand that it can limit the number of times I meet with Dr. Sheinberg and may have a maximum dollar amount or a set number of appointments allowed for therapy. I understand that the MCO is not obligated to use all these appointments.

Initial I understand that the business office may contact me if my form of payment is no longer working.

Initial If my account with Dr. Sheinberg is delinquent and arrangements have yet to be made for a payment plan, Dr. Sheinberg may use legal means to get paid. The only information Dr. Sheinberg will give to the court, a collection agency, or a lawyer will be my name and address, the dates we met for professional services, and the amount due to Dr. Sheinberg.

Initial I understand that payment is due at the time of service. Dr. Sheinberg accepts cash, personal checks, and major credit cards. The charge for a returned check is equal to the bank fee. When an NSF check is returned to Dr. Sheinberg, the office policy states that the patient can no longer write checks to Dr. Sheinberg. Cash, Venmo, Zelle, or major credit cards will be accepted as an alternative unless other arrangements are made with Dr. Sheinberg.

Initial Sessions that go over the allotted time (forty-five minutes) will be prorated according to her fee schedule. If I am late to my appointment, the session will end at the original end time.

APPEALS AND GRIEVANCES

Initial My insurance company does not delegate appeals and/or grievances to my practitioner. If my outpatient visits are denied certification, I acknowledge my right to request reconsideration (an appeal). I understand that I could request an appeal through my insurance company and risk nothing in exercising this right. I can request assistance from my practitioner should my insurance company require further information.

Initial I understand that I may submit a complaint or grievance to Dr. Sheinberg at any time to register a complaint about my care. I hope any concerns are first addressed with Dr. Sheinberg to reconcile any differences. I may also send the complaint directly to the appropriate governing board.

OFFICE USE ONLY

Dr. Sheinberg Initial _____ Date: _____

THERAPEUTIC RELATIONSHIP

Initial

My relationship with Dr. Sheinberg is professional and therapeutic. To preserve this relationship, it is imperative that Dr. Sheinberg not have any other type of relationship with me. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Dr. Sheinberg's care is about helping me but cannot be my friend or have a social or personal relationship with me. Gifts, bartering, or trading services are inappropriate and should not be shared between Dr. Sheinberg and me.

TERMINATION POLICY

Initial

Termination is a critical phase of treatment that helps prepare the patients to build on the gains and move forward positively after treatment ends. This crucial phase of treatment may be conceptualized from a range of perspectives, and it may stimulate several essential themes and issues to work through and address before treatment ends. If possible, treatment endings should not come as a surprise. I will work corroboratively with you toward a successful treatment ending. Termination should be considered a process and not an event. It should be seen as a phase of each patient's treatment that is worked together continuously. Because she works with her patients on a long-term basis, sometimes intermittently, the termination process in those cases is adjusted to consider this. However, much of what is written here does apply to all patients seen.

Initial

There must first be an agreement on treatment goals to know when treatment should end. While treatment goals may be modified over the course of treatment as patients make progress and life circumstances change, failure to have an open discussion of goals from the outset and failure to reach agreement on what these goals are impacts the nature, focus, and scope of the treatment offered as well as when and how this treatment will end. Knowing from the outset how treatment will end can be vital for patients to decide about participation in the proposed course of treatment. To meet Dr. Sheinberg's ethical obligations, she may need to end your treatment if you are not benefitting from treatment if inappropriate multiple relationships develop or are discovered, or if you no longer possess the competence necessary to meet your treatment needs. You may initiate termination for a variety of reasons. These may include financial hardships, dissatisfaction with Dr. Sheinberg or how the treatment is proceeding. While each of these cannot be anticipated from the outset of treatment, open discussions with patients about their progress in treatment and any issues that may impact their ability to continue should be explored and addressed periodically. Dr. Sheinberg will make an attempt to accommodate these unexpected situations.

Initial

Differentiating between abandonment and termination is essential. Abandonment occurs when Dr. Sheinberg does not appropriately meet a patient's ongoing treatment needs. Abandonment may occur when treatment endings are mismanaged and the patient's ongoing treatment needs are not adequately addressed. The latter may include failure to make needed coverage arrangements during periods of anticipated absence, such as vacations, attending a conference, or other times when patient access to the practitioner may be limited. Abandonment charges may even arise from not being sufficiently accessible between regularly scheduled treatment sessions.

Reasonable expectations must be established from the outset, with patients being provided with information on how to access the practitioner between sessions, when it is or is not appropriate to contact Dr. Sheinberg and the preferred means of contact. Realistic expectations should be established for Dr. Sheinberg's responsiveness outside of my session and when others should be contacted, such as calling 911 in emergencies. It is not abandonment when a patient drops out of treatment precipitously or does not fulfill treatment obligations. Nor is it abandonment if the patient cooperates with treatment recommendations and ends treatment appropriately, after discussion, with notice, and referrals being made. These actions may not be necessary when Dr. Sheinberg is threatened or assaulted. She has obligations as articulated in the informed consent agreement and/or treatment contract. When continued treatment is not possible or not indicated based on a patient's actions and responses, ending the treatment is not seen as abandonment. Dr. Sheinberg will document all such situations, discussions, consultations with colleagues, steps taken, and any efforts to contact the patient if treatment ends abruptly and/or precipitously.

Initial

How the psychotherapy relationship begins and ends has important implications for the patient. Addressing endings from the beginning and on an ongoing basis throughout treatment can help ensure that treatment is provided and ended in an ethical and clinically competent manner, which discourages any termination that solely involves using correspondence, phone calls, email, texts. Chronically missed appointments, and/or avoidance of any attempts to contact Dr. Sheinberg, Dr. Sheinberg may contact me with her concerns and can result in her referring me elsewhere.

Initial

All endings must be done in person.

OFFICE HOURS AND AFTER-HOURS EMERGENCIES

Initial

Office hours (subject to change) are Monday -Thursday, 7 a.m.- 6 p.m. Should medical or psychiatric emergencies occur after hours, call 911 or go to your nearest emergency center. Dr. Sheinberg will also provide after-hours contact information to reach her directly.

Initial

I understand if I contact Dr. Sheinberg outside my scheduled appointment, except to confirm an appointment, I am subject to a charge. This includes time spent on phone calls, email or texts. I understand that Dr. Sheinberg's policy is email and texts are transactional in nature and not clinical.

OFFICE USE ONLY

Dr. Sheinberg Initial _____ Date: _____

APPOINTMENTS

Initial Dr. Sheinberg has an individual policy about reminder calls, emails, or texts. However, I am still responsible for remembering my appointment time and day, whether a confirmation call, email, or text is placed.

Initial I consent to Dr. Sheinberg or an office staff member leaving me a voicemail, email, text, or message should they not reach me directly. Only information about dates and times of appointments will be sent. Clinical information will be exchanged through these communications if Dr. Sheinberg has specifically asked me to as a part of my treatment.

Initial I understand that I am responsible for remembering my appointment date and time. If an appointment is missed or canceled with less than 48 hours notice (or by corresponding appointment time on Thursday if the appointment is on Monday), I may be billed according to Dr. Sheinberg's fee schedule. Insurance may not be billed for these late cancelations or no-shows. Repeated no-show appointments will be addressed and could result in referring me to another practitioner.

Initial Dr. Sheinberg's commitment to her patients is evident in her efforts to accommodate their needs. While she does not intentionally double book or accept walk-ins due to the nature of her work, she makes every attempt to fill late canceled appointments. If I wish to avoid a charge for a missed appointment, I can request a virtual session. It's reassuring that Dr. Sheinberg values my time and will do her best to accommodate me.

Initial Therapy sessions are generally 45 minutes long. Dr. Sheinberg will discuss the length of the session and a fee schedule. The number of sessions needed depends on many factors, including designated goals, and will be addressed by Dr. Sheinberg.

IN CASE OF YOUR PRACTITIONER'S DISABILITY OR DEATH

Initial In keeping with our focus on your best interests, Dr. Sheinberg has made plans for all eventualities by making advanced arrangements to help ensure that I am not abandoned during treatment. Dr. Sheinberg has in place a professional, an identified colleague who will have access to patient contact information and records and contact patients in the case of Dr. Sheinberg's death or disability. The appointed professional will assess ongoing treatment needs and assist with crisis intervention and referrals to other clinicians. Should this be needed without warning, Dr. Sheinberg's office staff and appointed colleague will work together to ensure all the necessary information is provided from Dr. Sheinberg as soon as possible to inform, provide support, and make appropriate referrals.

OFFICE USE ONLY

Dr. Sheinberg Initial _____ Date: _____

CONFIDENTIALITY

I, Dr. Amy L. Sheinberg, will treat what you tell me with great care. My professional ethics (my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and regulations are how our society recognizes and supports the privacy of what we talk about, in other words, the "confidentiality" of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. Sometimes, the law requires me to say things to others. There are also some other limits to our confidentiality. We need to discuss these because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now so that you don't tell me something as a "secret" that I cannot keep secret.

1. When you or other persons are in physical danger, the law requires me to tell others about it. Specifically:

   a. If I believe you are threatening serious harm to another person, Texas state law requires me to try to protect that person. However, we will discuss thoroughly your intent to harm before breaking confidentiality. I understand that many feelings may surface if a breach is necessary, and I agree to explore these with you.

   b. If you seriously threaten or act in a possible way to harm yourself, I may have to seek a hospital for you or call on your family members or others who can help protect you. If such a situation arises, I will thoroughly discuss the situation with you before I do anything, explaining my concerns unless there is a solid reason not to do so (e.g., you cannot be reached, disagree with my decision despite compelling evidence, etc.) Ethics binds me to protect you from self-harm, and I will use my judgment and personal experience before doing so. Knowing this may create a severe breach of our relationship. We will discuss this in upcoming sessions that you feel ambivalent about attending.

   c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will get your permission first and discuss this with you as soon as possible afterward.

   d. If I believe or suspect you are abusing a child, an older adult, or a disabled person, I must file a report with a state agency. "Abuse" means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation and find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

   In any of these situations, I would reveal only the information needed to protect you or the other person. I would not tell everything you have told me.

2. If you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. This is called "privilege," and it is your choice to prevent me from testifying or allow me to do so. However, there are some situations where a judge or court may require me to testify (listed below). However, I do not believe I serve you best when litigation is possible. I will refer you to a forensic colleague in those cases. Should litigation arise during your treatment, please refer to the form Forensic Matter and Court Appearances. These forms must be signed before treatment begins with you.

   a. Your fitness as a parent is questioned or in doubt in child custody or adoption proceedings. I agree to speak only to a court-appointed forensic clinician in these matters.

   b. In cases where your emotional or mental condition is essential to a court's decision, I agree to speak to any court-appointed clinician.

   c. During a malpractice case or an investigation by a professional group of another therapist or me.

   d. In a civil commitment hearing, decide if you will be admitted to a psychiatric hospital.

   e. I do not see individuals for court-ordered evaluations or treatment. In those cases, I would need to thoroughly discuss with the court-appointed clinician because you don't have to tell them what you don't want the court to find out through their report.

3. There are a few other things you must know about confidentiality and your treatment:

   a. I may sometimes consult (talk) with another professional about your treatment. Professional ethics also requires this other person to keep your information confidential. I will omit certain identifying information when appropriate. Likewise, another therapist will be available to help my patients when I am out of town or unavailable. Like you, I must give him or her some information about my patients.

   b. I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record seriously upsets you, I may leave it out, but I will fully explain my reasons. I may keep two separate records for you. My progress notes can be legally subpoenaed; my clinical notes, including my impressions,cannot.

4. Finally, here are a few other points:

a. I will not record our therapy sessions on audiotape or videotape without your written permission.

b. If you want me to send information about our therapy to an appropriate professional, you must sign a Request/Authorization to Release Confidential Records and Information form. These forms are online, so you will know what is involved.

c. Any information you share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Situations not mentioned here rarely arise in my practice.
Please bear in mind that I cannot give you legal advice. If you have unique or unusual concerns and need particular advice, I strongly suggest you talk to a lawyer to protect your interests legally.

If the undersigned practitioner reasonably believes that I am physically or emotionally dangerous to myself. I expressly consent for the practitioner to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Signature of patient _____ Date _____

Printed name of patient _____

Signature of Amy L. Sheinberg, Ph.D. _____ Date _____

Amy Sheinberg, Ph.D.
8333 Douglas Ave., Suite 1240 Dallas, TX 75225
214 361 0660

Notice of Privacy Practices

To my patients: This notice describes how health information about you (as a patient in my practice) may be used and disclosed and how you can access your health information. This is required by the Privacy Regulations created due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Commitment to Your Privacy

My practice is dedicated to maintaining the privacy of your health information. I am required by law to provide you with the following important information explaining your rights and my obligation to maintain your privacy.

Uses and Disclosures Requiring Authorization

Your signature on the agreement to enter into treatment with me provides consent for me to use or disclose your protected health information (PHI) in the course of treatment, payment, and health care operations purposes. This would include consultations with other professionals who are also legally bound to keep the information confidential; any clinical or administrative personnel responsible for billing; and any contract I may have with an agency associated with your care and health service, which promises to maintain confidentiality except as specifically allowed in the agreement or otherwise required by law.

I may release information for other purposes with your permission and written authorization. When I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain authorization from you before releasing this information. You may revoke all such authorizations at any time, in writing, unless 1) I have taken action in reliance on it, or 2) if the authorization was obtained as a condition of obtaining insurance coverage; or 3) if you have not satisfied any financial obligations, you have incurred.

Uses and Disclosures Requiring Neither Consent Nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Harm or Abuse: When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual, or the public. I must report any child abuse, adult, or domestic abuse suspicion to the appropriate authorities

- Health Oversight: The law authorized public health authorities and health oversight agencies to collect information.

- Judicial or Administrative Proceedings: Privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered, and I am required to release information.

- National Security: If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities, to federal officials for intelligence and national security activities authorized by law.

- Law Enforcement Officials: To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

- Worker's Compensation: I may disclose your diagnosis and treatment records to your employer's insurance carrier for Worker's Compensation or similar programs.

Your Rights Regarding Your Health Information

Communications: You can request that my practice communicates with you about your health and related issues in a particular manner or at a specific location. For instance, you may ask that I contact you at home rather than at work. I will accommodate reasonable requests.

Good Faith Estimate: Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/no surprises or call 1-877-696-6775.

Restrictions: You can request a restriction in my use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that I restrict the disclosure of your health information to only specific individuals involved in your care or the payment of your care. I am not required to agree with your request. However, if I do agree, I am bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Inspect and Copy: You have the right to inspect or obtain a copy of the health information that may be used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but you may have this decision reviewed in some cases.

Amend: You have the right to request an amendment of your health information if you believe it is incorrect or incomplete, as long as this information is kept by and for my practice. Your request must be made in writing and submitted to me at the address on the letterhead. You must provide a reason that supports your request. I may deny your request, however.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with my practice or the Department of Health and Human Services Secretary. To file a complaint with my practice, contact me at the address on the letterhead. All complaints must be in writing. You will not be penalized for filing a complaint.

Other Authorizations and Accounting: My practice will obtain your written authorization for uses and disclosures not identified by this notice or permitted by applicable law. You generally have the right to receive an accounting of any disclosures of your information made without your consent or authorization.

If you have any questions regarding this notice or my health information privacy policies, please contact me at the phone number on the letterhead. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

Receipt of Notice of Privacy Practices

ACKNOWLEDGEMENT

I hereby acknowledge that I have received/been offered a copy of the Notice of Privacy Practices for Amy L. Sheinberg, Ph.D., LLC. I understand a signed copy will be kept in my file.

SIGNATURE OF PATIENT _____ **DATE** _____

NAME OF PATIENT (printed) _____

SIGNATURE OF Amy L. Sheinberg, Ph.D. _____ **DATE** _____

CONSENT FOR EMAIL/TEXT COMMUNICATION

I will be happy to respond to your query within reason, but to do so via email or text, you must provide your consent, recognizing that email or text is not secure communication. There is some risk that any protected health information in an email or text may be disclosed to or intercepted by unauthorized third parties. I will use the minimum amount of protected health information necessary to answer your query. Communication technologies must never replace the critical interpersonal contacts that are the basis of the patient-psychologist relationship. Patient-psychologist electronic mail is defined as computer-based communication between psychologists and patients within a professional relationship. The psychologist has taken on direct responsibility for the patient's care. These guidelines do not address communication between psychologists and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

COMMUNICATIONS GUIDELINES:

I will return email or text as soon as possible, but within 24 hours of receipt during business hours. I will not exchange clinical information via text or email. Email or text may or may only be returned if I am on vacation once I return. I will have a practitioner on call for emergencies. You must call my office for that information. If an exception is made to communicate via text or email, a corresponding charge will be based on Dr. Sheinberg's current session rate.

All email or text communication will be retained by paper or electronic copies for the term applicable to paper records. I will back up all communication weekly.

Therapeutic communication (sensitive subject matters) should be kept at a minimum. Please call to set up an appointment for therapeutic issues.

Email correspondence or text will not be used to establish a patient-psychologist relationship. E-mail should not supplement other, more personal encounters. Email or text can be misinterpreted in tone and meaning without face-to-face interaction.

Email or text communication to cancel or reschedule an appointment is acceptable.

Please put the nature of the communication (e.g., appointment, advice, billing question) in the subject line. Please ensure your name and identifying information about the patient care are in the message's body. All business matters such as needing an Encounter Form should be directed to 214-361-0660 or at office@amysheinbergphd.com.

Please be concise in your email or text. Please call to schedule an appointment if the matter cannot be written concisely.

I will also send you a message to inform you of the completion of the request.

If you do not adhere to these guidelines, you will be reminded that I will terminate the email or text relationship if necessary.

Encrypted messages are the most secure form of communication. However, I can only ensure encryption on my side.

My computer(s) is/are password protected.

Your email or text will only be forwarded to a third party with your permission if you have already signed a release for me to communicate with a professional.

Your email or text address will not be used in any marketing scheme.

My office manager and I are the only ones with access to my email or text address and mobile number.

I will double-check all "To" fields before sending messages.

These policies also apply to facsimile communications or texts.

A. General email or text risks include but are not limited to the following:

- Email or text can be immediately broadcast worldwide and received by many intended and unintended recipients;
- Recipients can forward email or text messages to other recipients without the original sender's permission or knowledge;
- Users can easily send an email or text to the incorrect address;
- Email or text is easier to falsify than handwritten or signed documents;
- Backup copies of email or text may exist even after the sender or the recipient has deleted his or her copy.

B. Specific email or text risks include but are not limited to the following:

- Email or text containing information about a patient's diagnosis and treatment must be included in the patient's medical records. Thus, all individuals who have access to medical records will have access to email or text messages.
- If you are sending your email or text from your employer's computer, your employer can access your email.
- While it is against the law to discriminate, and Texas subscribes to a "no cause" termination policy, an employer with access to your email or text can use the information to discriminate against the employee. Additionally, the employee could suffer social stigma from a workplace disclosure.
- Insurance companies who learn about your Personal Health Information (PHI) could deny coverage.
- Although Dr. Sheinberg will endeavor to read and answer email or text correspondence promptly, they cannot guarantee that any particular email or text message will be read and responded to in any specific time frame. The exception would be that the email or text is part of a scheduled time frame for a prepaid email or text counseling session. I do not offer email or text therapy sessions.

C. Conditions for the use of email or text: All emails or texts that concern your diagnosis or treatment or that are part of your medical record will be treated as part of your PHI. Reasonable means will be used to protect the security and confidentiality of the email. Because of the risks outlined above, the security and privacy of email or texts cannot be guaranteed; your consent to email correspondence includes your understanding of the following conditions:

- All email or texts to and from you concerning your PHI will be a part of your file and can be viewed by health care, insurance providers, and the practitioner's office support staff.
- Your email or text will not be forwarded outside the office without your consent or as required by law.
- Though all efforts will be made to respond promptly, this may not be the case. Because the response cannot be guaranteed, please do not use email or text in a medical emergency.
- If you have not received a response, you are responsible for following up with the practitioner or support staff.
- Medical information is sensitive, and unauthorized disclosure can be damaging. You should not use email or text for communications concerning the diagnosis or treatment of AIDS/HIV infection, other sexually transmissible diseases, mental health, developmental disability, or substance abuse issues.
- Since employers do not observe an employee's right to privacy in their email or text system, you should not use you employer's email or text system to transmit or receive confidential email or text.
- The practitioner will take reasonable steps to ensure that all information shared through email or text is kept private and confidential. However, Amy Sheinberg, Ph.D., is not liable for improper disclosure of confidential information resulting from our negligence or misconduct. Patient information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2 Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2., A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the data to investigate any alcohol or drug abuse.

INFORMED CONSENT

- If you consent to email or text, you are responsible for informing your practitioner of any information you do not want to be sent to you by email or text other than the information detailed in Section B.
- You are responsible for protecting your password and access to your email or text account and any email or text you send or receive from Amy Sheinberg, Ph.D., to ensure your confidentiality. Your practitioner cannot be held liable if a breach in your account security causes a violation of privacy.
- Any email or text you send discussing your diagnosis or treatment constitutes informed consent to transmitted information. Suppose you wish to discontinue emailing or texting data. In that case, you must submit written permission or an email or text informing your practitioner that you are withdrawing consent to email or text information.

_____ Yes, I have read the above and consent to the possibility that email and texts may not be encrypted from user to user. However, all received will be kept confidential and in an encrypted file.

_____ No, I am not interested in email/text correspondence. In that case, you will not receive confirmation email reminders.

Signature of Patient _____ Date _____

Printed Name of Patient _____

Signature of Amy L. Sheinberg, Ph.D. _____ Date _____

TELETHERAPY SERVICES AGREEMENT AND INFORMED CONSENT

Amy Sheinberg, Ph.D. 8333 Douglas Ave., Suite 1240 Dallas, TX 75225

1. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. Any personal information you share with me will be held in the strictest confidence. I will not release your information to anyone without your prior approval, or I am required to do so by law. In Texas, we are not required to notify authorities if we become convinced you are a physical danger to yourself or someone else. We also have a duty to inform the authorities if there is suspicion or evidence of abuse of children, the elderly (over 65), or people with disabilities.

2. You understand that our teletherapy occurs in Texas and is governed by state laws. I, the practitioner, am accountable to and agree to abide by the ethical and legal guidelines prescribed by the state of licensure and residence. The patient agrees to these terms. If you do not understand or have questions regarding this issue, please ask for clarification. You use modality to visit me in my Texas office. I have applied for a "passport," allowing me to continue our treatment uninterrupted should you go to school, vacation, or temporarily work out of state.

3. We are free to terminate teletherapy anytime and for any reason. If you decide to terminate, please discuss your reasons in a session. If I become convinced our teletherapy is not in your best interests, I will explain it to you and suggest some alternative options better suited to your needs.

4. You understand that teletherapy is neither a universal substitute nor the same as face-to-face psychotherapy treatment. You accept the distinctions made using teletherapy vs. face-to-face psychotherapy. In particular, you acknowledge that teletherapy may not be a substitute for emergency services.

5. You are responsible for information security on your computer. Facetime are currently not considered HIPAA-compliant encrypted applications. There are HIPAA-approved video conferencing services available. Dr. Sheinberg will use Zoom for all virtual sessions.

6. Teletherapy is how you can receive psychotherapy, information, and guidance from an experienced psychologist. It is perhaps most accurately perceived as a process of creating, over time, a trusting and collaborative relationship. You retain the right to determine which topics we cover and the depth of consideration each receives. You are free to contribute or withhold any information you choose. Current studies support the usefulness of Teletherapy.

Telecommunication: Teletherapy uses electronic transmissions to treat a patient's needs. I offer video and audio communication via the Internet and/or telephone. This means practicing health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

The risks involved with teletherapy include the potential release of private information due to the complexities and abnormalities of the Internet. Viruses, Trojans, and other involuntary intrusions can grab and release information you may desire to keep private. Furthermore, there is the risk of being overheard by anyone near you if you do not place yourself in a private area. The advantages of teletherapy include the benefit of continuity of care in the absence of your therapist and the ability to be treated from any location at any time. Your responsibility is to create an environment on your end of the teletherapy transmission that is not subject to your personal information's unexpected or unauthorized intrusion. It is MY responsibility, the practitioner, to do the same.

Signature of patient _____ Date _____

Printed Name of Patient _____

Signature of Amy L. Sheinberg, Ph.D. _____ Date _____

Date _____ Clinician(s) Dr. Sheinberg

Patient Name _____

Cardholder Name _____

Billing Address (of credit card)_____

Credit Card ( ) Visa ( ) MasterCard ( ) AMEX ( ) Discover

HSA CARD

Also requires a non-HSA card

HSA Card Number _____ Exp _____ CVV _____ Zip Code _____

Non-HSA Card _____ Exp _____ CVV _____ Zip Code _____

CREDIT CARD

Card Number _____ Exp _____ CVV _____ Zip Code _____

Card Number _____ Exp _____ CVV _____ Zip Code _____

Card Number _____ Exp _____ CVV _____ Zip Code _____

Card Number _____ Exp _____ CVV _____ Zip Code _____

Authorized signature to use credit card(s) _____

Signature of Amy L. Sheinberg, Ph.D. _____ **Date** _____

Please notify us as soon as possible if credit card information changes.

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

Patient Name: _____ Birth date: _____

Address: _____

Parent/Guardian (if applicable): _____ Phone: _____

Address of parent/guardian: _____

I hereby authorize Amy Sheinberg, Ph.D. to receive/send psychological, psychiatric, educational and/or personal information on the above named patient to/from the following individual and/or facility.

Person or Facility: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

A. I hereby authorize the source named above to send or call, as promptly as possible, the records on outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug/alcohol abuse.

B. I authorize the named above to communicate with the Dr. Sheinberg about the reasons for patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

C. I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my treatment.

D. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 s. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

E. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

F. This request/authorization is valid during the pendency of any claim or demand made by or on behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive.

G. I agree that a photocopy of this form is acceptable. By signing this form, I am approving this form of communication.

H. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

Signature of Patient _____ Printed Name _____ Date _____

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Amy L. Sheinberg, Ph.D. _____ Amy Sheinberg, Ph.D. Date _____

Mentalyc Informed Consent

General Notice

I have a legal and ethical responsibility to make my best efforts to protect all communications that are part of our psychotherapy sessions. I have chosen to use Mentalyc's note-taking system for psychotherapy as part of my effort to provide the best care to my clients. It provides me with an automatically generated transcript and summarization of our sessions. Mentalyc's system is HIPAA compliant and uses up-to-date encryption methods, firewalls, and backup systems to help keep your information private and secure. You are consenting for me to record our sessions using Mentalyc's system.

Details

Recordings of our sessions will be transcribed and summarized by Mentalyc's HIPAA compliant technology. Mentalyc doesn't store the recordings and client personal information. I may choose to keep the summarized notes as part of your confidential medical record. Mentalyc does not have my permission to keep any data to help improve the tool. As with any technology, there are certain risks and benefits, which I will list here:

Risks:

- All technology contains a risk of confidential information being disclosed. You can ensure the security of our communications by only using trusted secure networks for psychotherapy sessions and having passwords to protect the device you use for psychotherapy. Mentalyc mitigates this risk by ensuring up-to-date technological security and storing the data with as little identifying information as possible.
- Mentalyc researchers will NOT have access to your de-personalized transcripts (transcript content with removed names, emails, and other identifying information).
- The system may contain unknown bias in the way it generates the session summary and presents clinical information. This risk is mitigated by your therapist's commitment to review and modify the note as needed using their clinical expertise (i.e., I go through the note and make corrections or additions where necessary).

Benefits:

- The technology allows the therapist to focus more of their attention on therapy.
- Removes the need for taking notes or trying to remember information during and after the session.
- Mentalyc reduces the therapist's workload and may help with compassion fatigue.
- The technology may provide additional clinical insights for the therapist which helps improve outcomes in the therapeutic process (i.e., hoping to get home before I turn into a pumpkin).
- My notes are stored in a two-factor authenticated program where the note itself is in a password-protected file and encrypted.

By signing this consent, you are agreeing to allow your therapist to use the Mentalyc software.

Printed Name:_____

Signature: _____ Date: _____

Reviewed with patient/ALS: _____ Date:_____

Amy L. Sheinberg, Ph.D.
8333 Douglas Ave., Suite 1240 Dallas, Texas 75225
214-361-0660 • amysheinbergphd.com

FORENSIC MATTERS:
AGREEMENT CONCERNING PSYCHOLOGIST'S TESTIMONY AND RECORDS

This agreement ["**Agreement**"] is made between Amy L. Sheinberg, Ph.D. ["**Psychologist**"], and [the "**Patient**"] _____, this _____ day of _____, 20____, in order to state certain conditions under which the Psychologist will provide professional mental health services for the Patient. In the event that this Agreement is signed after treatment of the Patient has begun, the Patient agrees that this Agreement shall be treated as if signed and effective immediately prior to the first day of treatment of the Patient.

TESTIMONY

The Psychologist has determined, and the Patient agrees, that the Patient's emotional health and need to know the sessions are confidential outweigh the need for the Psychologist or her records to be available for any current or future litigation concerning the Patient. The Patient agrees that he/she will not require the Psychologist to testify (deposition, courtroom testimony, or otherwise), concerning Patient's treatment in any current or future litigation. Further, the Patient will not request or subpoena the records of the Psychologist concerning her treatment of the Patient for use in any current or future litigation.

In the event Patient either attempts to subpoena or workout a separate agreement with the Psychologist or her records, Patient agrees to pay all costs and attorney's fees incurred by the Psychologist, including fees for her time in defending any attempt to defeat this Agreement and results in her testifying or producing her records. In the event the Psychologist's deposition is taken, whether by court order or otherwise, the Patient agrees to compensate the Psychologist for 8 hours of her time, regardless of the length of the deposition (unless it lasts longer than 8 hours), at an hourly rate of $600 per hour. The $4800 deposition fee will be paid in advance of the commencement of the deposition. The Patient further agrees that any deposition of the Psychologist will take place in Dallas County, Texas at a location of the Psychologist's choosing, on a date convenient with her work and personal schedule.

Additionally, the Patient shall also compensate the Psychologist's attorney of her choosing for his/her time in defending this Agreement, either by representing and protecting the rights' of the Psychologist or in contesting the Patient's right to request a deposition and/or records, including but not limited to motion drafting and hearing attendance, deposition preparation time, actual time in the deposition, courtroom testimony preparation time, and actual time spent presenting and defending the Psychologist in court, all at the attorney's then-prevailing hourly rate. Payment of the Psychologist's attorney's fees shall be made upon presentment of same, either to the attorney of record or to the Psychologist who will forward to the attorney. This bill is to be paid by the Patient within three (3) business days upon receipt. Failure to pay within that time frame could result in added late fees.

The Patient acknowledge that:

- The Psychologist's testimony will in no way be influenced by the fact that the Patient is paying the fee; and
- The Patient understands that the Psychologist's testimony may be prejudicial to the Patient's legal position.

The Patient acknowledges and understands that litigation is time-consuming and takes up the Psychologist's time that could otherwise be applied to treating the Psychologist's other patients. Thus, the Patient further agrees to compensate the Psychologist for her time spent (1) reviewing records in preparation for any hearing, deposition, or trial; (2) in responding to any written discovery requests; and (3) rescheduling any patients inconvenienced by said litigation. Time for the aforementioned will be billed separately to the Patient at the same $600 hourly rate, and is to be paid within three (3) business days upon receipt. Failure to pay within that time frame could result in added late fees.

RECORDS
Should production of records be requested, the Patient understands that the following applies for document production:

- The Psychologist will produce records only if Court-ordered (subpoenas for same will be challenged);
- The Patient agrees to pay the full amount of the fees listed in the following section;
- The Patient understands that the Psychologist's records will in no way be influenced by the fact that the Patient is paying the fee; and
- The Patient understands that the Psychologist's records may be prejudicial to Patient's legal position.

The fees to be paid and received in full prior to the Psychologist's production of the records are:

a. Three (3) hours ($1800) of preparation time for review and gathering of clinical records and supporting documents;
b. If a summary of such records is requested, time spent preparing the summary will be charged at the rate of $600 per hour;
c. An administrative fee of $0.50 cents per page for any records copied and produced;
d. Any time spent preparing responses to any written discovery requests will be charged at the same hourly fee rate ($600) noted above; and
e. Any time spent by the Psychologist's attorney, at his/her hourly rate at the time the work is performed, in reviewing and/or objecting/responding to the records requests or other written discovery requests.

The reason the fee is paid up front reflects the reality that the Psychologist could not go into Court with the Patient owing a large bill. This would leave the Psychologist open to a question as to whether the financial situation had influenced the Psychologist's judgment. This is not an acceptable situation for the Patient and the Psychologist will adhere strictly to this policy.

The Patient further acknowledges that mental health professionals have a duty to deny access to the Patient's records if the professional determines that release of said records would be harmful to the Patient's physical, mental, or emotional health and therefore the Patient may be denied access to information concerning treatment of the Patient if such a determination is made by the Psychologist. If court ordered, could be reviewed by the appointed judge who will have the knowledge that these records have be withheld from the Patient due to the aforementioned reasons.

This Agreement has been explained to the Patient; the Patient has been given the opportunity to have it reviewed by counsel of Patient's choosing; the Patient agrees that this Agreement was mutually negotiated between Patient and Psychologist and shall not be construed against any signatory hereto; and the Patient agrees to abide by this Agreement and has been offered a copy of this Agreement which will be kept on file by the Psychologist.

Date: _____ Signature of Patient _____

Printed name of Patient _____

I have reviewed this Agreement with the Patient prior to Patient's signing this Agreement.

Dated this _____ day of _____, 20____.

Signature of Amy L. Sheinberg, Ph.D. _____

Amy L. Sheinberg, Ph.D.

ADULT INTAKE QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date _____

REASON(S) FOR TODAY'S VISIT

What is your reasons for seeking psychotherapy at this time? _____

_____

_____

_____

How long have you been experiencing these issues? _____

Did something(s) precipitate them recently? _____

_____

What has the course of these symptoms been? _____

When did others first notice these symptoms? _____

What would you like to get out of our work together? Specific Goals? _____

_____

_____

MEDICAL AND MENTAL HEALTH HISTORY

Have you previously seen a therapist or psychiatrist? _____ Who? _____ When? _____

For what reason(s)? _____

_____

Was it helpful? _____ If not, why? _____

PSYCHIATRIC MEDICATIONS

Medication	Dosage	When prescribed	Prescribed by	Response

PAST PSYCHIATRIC MEDICATIONS:

Medication	Dosage	Date taken	Prescribed by	Reason(s) discontinued

If you have been admitted for psychiatric reasons, please describe (e.g., psychiatric hospitalization, outpatient day program, wilderness program, therapeutic boarding school, residential treatment center, intensive outpatient treatment).

Program	When attended	Response to care received

Have you have ever had academic, psychological, and/ or neuropsychological testing? Please describe.

Type of Testing	When	Evaluator	Results	Copy accessible

What psychiatric/psychological diagnoses have you been told you have? _____

If you have ever taken any other "personality" tests, please check any that apply.

☐ Enneagram ☐ Aptitude Test ☐ Clifton Strengths Assessment ☐ Other: _____

☐ Myers-Briggs Type Indicator (MBTI) ☐ DiSC ☐ The Big Five Personality Traits _____

Have you ever tried to harm yourself in the past? Please describe. _____

Have you ever had thoughts of committing suicide in the past? Please describe. _____

Have you ever attempted suicide in the past? Please describe. _____

Have you ever had a substance abuse problem in the past? Please describe. _____

Have you had any significant medical conditions in the past? If so, please explain. _____

_____

CURRENT SYMPTOMS AND CONCERNS:

Please describe in detail how the symptoms listed below have impacted you over the last 4-6 weeks:

Difficulty sleeping: _____

Changes in appetite or dietary habits: _____

Mood: _____

Anxiety: _____

Depression or feelings of hopelessness: _____

Thoughts and/or gestures of self-harm: _____

Thoughts, plans, and/or intentions to attempt suicide: _____

Other troubling symptoms? Please be as specific as possible. _____

What are your most distressing symptoms? _____

How do your symptoms interfere with your day-to-day functioning in the following areas:

Relationships: _____

Work and/or school performance: _____

Activities of daily living - hygiene, taking care of your pet, keeping up with interests/hobbies: _____

_____

Executive functioning - attention, organization, working memory, self-control, problem-solving, initiation, and self-monitoring:

_____

Do you have any ongoing medical conditions? If so, please explain. _____

_____

Do you have any medication allergies? _____

FAMILY PSYCHIATRIC HISTORY:
Has any family member had any of the following? Please indicate which family member and whether maternal (M) or paternal (F)

_____ ADHD
_____ Alcohol Abuse
_____ Anxiety
_____ Autism/Asperger's Disorder/PDD
_____ Coordination Problems
_____ Depression
_____ Developmental Disorder
_____ Drug Use
_____ Eating Disorder
_____ Learning Disability
_____ Legal Problems`
_____ Mania/Bipolar Disorder
_____ Movement Disorders
_____ Obsessions/Compulsions
_____ Panic
_____ Psychiatric Hospitalizations
_____ Psychosis
_____ Rituals
_____ Sleep Disorder
_____ Suicidal thoughts/urges behaviors
_____ Tics
_____ Unusual noises/vocalizations
_____ Other _____
_____ Other _____

FAMILY MEDICAL HISTORY

Please provide information about significant medical issues on the BIOLOGICAL FATHER'S side: _____

_____

Please provide information about significant medical issues on the BIOLOGICAL MOTHER'S side: _____

_____

YOUR PRENATAL HISTORY:

Was your mother's pregnancy with you healthy? Yes No Problems: _____

Were medications used during her pregnancy? Yes No If yes, what kind? _____ How Often? _____

Were drugs/alcohol used during her pregnancy? Yes No If yes, how much/often? _____

Did your mother smoke during her pregnancy? Yes No If yes how much? _____

Was the pregnancy full term? Yes No Was delivery normal? Yes No If no, problems? _____

Any feeding problems? Yes No Gain weight well? Yes No

Were there any problem in the first week? _____ First month? _____ First year? _____

Total number pregnancies had by your mother: _____ Live births: _____ Your birth order: _____

DEVELOPMENTAL HISTORY:

1. Describe yourself as a child: *(check one)*

(a) active ☐ active but calm ☐ passive ☐ **(b)** cuddly ☐ irritable ☐ withdrawn ☐

(c) cried easily and frequently ☐ reasonable amount ☐ seldom ☐ **(d)** *reaction to strangers:* friendly ☐

indifferent ☐ fearful ☐ **(e)** *response to changes:* severe ☐ moderate ☐ mild ☐

(f) soothed easily ☐ difficult to soothe ☐ average ☐

2. Developmental milestones Early ☐ On time ☐ Late ☐ Describe, if late: _____

FAMILY OF ORIGIN

Are your parents still living? _____ Are your parents still married? _____ If your parents divorced, when did they divorce? _____

How old were you? _____ Reason(s) you were given for their divorce. _____

_____

Mother's name: _____ Mother's occupation: _____

How would you describe your relationship with her? _____

Father's name: _____ Father's occupation _____

How would you describe your relationship with him? _____

If there are stepparents (or other significant relationships), how would you describe your relationship with them? Are they supportive of you?

Siblings

Names:	Ages:	Occupation/School Status:	Your Relationship?

YOUR RELATIONSHIP STATUS

Are you married or in a significant relationship? _____ How long have you been together/married? _____

Name of significant other _____ Occupation _____

How would you describe your relationship? _____

What would you like to see improve in your relationship? _____

Do you have children? _____ Number of pregnancies _____ Number of live births _____

Name(s) of children	Age(s)	Grade/Occupation	How would you describe your relationship?

Are any immediate family members living elsewhere? Please elaborate.

Have there been any recent changes in your family life? Please describe.

LIFESTYLE AND HABITS

Do you currently use alcohol, tobacco, and/or other substances (illicit, OTC, or someone else's prescription medication)? If yes, what, how much, and how often?

Do you believe or have others suggested to you that you currently have a substance use/abuse problem? Please elaborate on this.

Describe your diet. _____

Caffeine: Coffee? Yes ☐ No ☐ How many daily? _____ Tea? Yes ☐ No ☐ How many daily? _____
Cola? Yes ☐ No ☐ How many daily? _____

What do you do for exercise? _____ How frequently? _____ Level of intensity? _____

Current weight _____ Ideal weight _____ Past year's highest weight _____ Lowest weight _____ Current height _____

Describe your social media and technology usage. _____

Have you (or others) noticed any mood, affect, or behavior changes during or after sustained social media use? Please elaborate.

What are your interests and hobbies? _____

What would your ideal weekend look like? _____

What would your ideal vacation look like? _____

How do you relax? _____

What do you like to do for fun? _____

What was the last book you read? _____

What was the last movie you watched? _____

What are your favorite streaming shows? _____

EDUCATION AND OCCUPATIONAL BACKGROUND

What is the highest level of education you have completed? _____

Name of school? _____ Degree obtained? _____

Are you currently employed or attending school? If so, where and what are you studying or doing?

Have you had any difficulties at school and/or work? Please describe: _____

Do you consider yourself someone who lives to work or works to live, and why? _____

Where do you see yourself in 1 year? _____

5 years? _____

EMOTIONAL AWARENESS, COPING MECHANISMS, AND SELF-CARE

Describe your thoughts and feelings when you're experiencing stress: _____

How do you typically respond to stress? _____

Describe a recent situation where you felt overwhelmed. _____

What did you do to cope with the above situation? _____

What would you like to improve about how you cope with stress in general? _____

How do you typically deal with sadness? _____

How do you typically deal with anxiety? _____

How do you typically deal with frustration? _____

How do you typically deal with anger? _____

How do you express yourself when you are happy? _____

What would you like to improve upon regarding how you typically cope with your moods changes? _____

What activities or practices help you relax and improve your mental health? _____

Where would you like to be emotionally in 1 year? _____

What values are most important to you and why? _____

Were you raised with a religion? Which one? How did it influence you? _____

What are your current religious or spiritual views? _____

SOCIAL HISTORY

Who are the important people in your life? _____

What makes those relationship(s) important?

How connected and/or supported do you feel to the people around you?

How would you describe your relationships with your friends?

In what ways could they support you better?

What would you like to see improve in your relationships?

Have there been any recent changes in your social life/relationships? Please describe.

SELF-PERCEPTION AND IDENTITY

What are the things you love most about yourself, and why?

How would you describe yourself?

How do you think others would describe you?

What values and/or beliefs most influence you and why?

What do you think are your greatest strengths?

What do you think are your psychological blind spots? These could include biases, shortcomings, unhealthy, or maladaptive patterns.

How do you feel about your current life situation?

What would you like to see change about your current life situation?

In general, how do you handle change?

In addition to changes in your personal life, changes occur daily. How closely do you pay attention to the news? How affected are you by what you read or watch? How did you handle the pandemic?

What worries do you have about local, national, or world issues?

FUTURE ASPIRATIONS AND CONCERNS

What are some goals or dreams you're currently working towards? How did you choose those? How are you working to develop them?

What do you worry about most regarding your future?

What excites you most about the future?

What is on your bucket list?

MENTAL HEALTH AWARENESS

Have you ever felt that discussing mental health is difficult or stigmatized in your environment? How does that affect you?

How do your friends or peers talk about mental health issues? Do these conversations impact how you view your mental health?

THE MELTING POT

What's one thing you've always wanted to try but haven't yet?

If you could have dinner with anyone, living or dead, who would it be and why?

What's a small act of kindness you recently witnessed or experienced?

What was the last act of kindness you performed?

If you could instantly become an expert in one subject, what would it be and why?

What are somethings you're looking forward to in the near future and why?

What are some skills or hobbies you'd like to develop further?

If you could relive one day of your life, which day would it be and why?

What's the best piece or pieces of advice you've ever received?

If you could have any superpower, what would it be and how would you use it?

If you could send messages to your younger self, what would tell yourself?

If you knew when you would die, what would you do differently starting today?

What do you want to be known for when all is said and done?

What do you wish more people knew about you?

What would you be most ashamed of if it were to become public?

What would your last meal be?

After completing this questionnaire, are there other things about yourself you'd like to explore?

What haven't I asked about you that you would like me to know?

Is there anything you would like to know about me?

PROBLEM BEHAVIOR CHECKLIST: DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS?

RATE FROM ONE (NEVER) TO FIVE (VERY OFTEN)

- ☐ I have no problems or concerns
- ☐ Abuse-
- ☐ physical
- ☐ sexual
- ☐ emotional neglect (of children or elderly persons)
- ☐ Accident prone
- ☐ Affectionate
- ☐ Aggression
- ☐ Alcohol abuse
- ☐ Anger
- ☐ Anxiety
- ☐ Appetite changes
- ☐ Argumentative
- ☐ Attention, concentration, distractible
- ☐ Baby talk
- ☐ Body Image
- ☐ Bossy towards others
- ☐ Breaks rules/laws
- ☐ Bullied by others
- ☐ Bullies others
- ☐ Career concerns, goals, and choices
- ☐ Cheating
- ☐ Childhood issues (your own childhood trauma)
- ☐ Chronic pain
- ☐ Clowning around (frequent)
- ☐ Codependency
- ☐ Competitive
- ☐ Conflicts at home at school
- ☐ Conflicts with friends
- ☐ Controlling, demanding
- ☐ Cries often/frequently
- ☐ Cruelty to animals
- ☐ Daydreamy
- ☐ Decision making
- ☐ Deliberately annoy people
- ☐ Delusions (false ideas)
- ☐ Dependent/clingy
- ☐ Depression, low mood, sadness, crying
- ☐ Destructive/violent
- ☐ Difficulty expressing feelings
- ☐ Disobedient
- ☐ Disorganized
- ☐ Drug use
  - ☐ prescription medications
  - ☐ over-the-counter medications
  - ☐ street drugs
- ☐ Easily angered, bad temper
- ☐ Easily riled up
- ☐ Eating disorder - ARFID
- ☐ Emptiness
- ☐ Failure
- ☐ Fantasy life
- ☐ Fatigue, tiredness, low energy, listlessness
- ☐ Fears
- ☐ Feelings of worthlessness, inferiority
- ☐ Feels sick often
- ☐ Financial or money troubles, debt
- ☐ Frequent accidents
- ☐ Friendships, making and/or maintaining
- ☐ Goal setting
- ☐ Grief
- ☐ Guilt
- ☐ Hair pulling
- ☐ Headaches, migraines
- ☐ Health
- ☐ Hyperactive
- ☐ Hypochondria
- ☐ Impulsivity, loss of control
- ☐ Interpersonal conflicts
- ☐ Intrusive thoughts
- ☐ Irritability
- ☐ Isolation
- ☐ Irresponsible problem solving
- ☐ Lack of interest in activities
- ☐ Lacks respect for authority
- ☐ Laziness
- ☐ Learning difference(s)
- ☐ Legal matters
- ☐ Loneliness
- ☐ Loss of focus
- ☐ Loss of friends/relationships
- ☐ Low frustration tolerance
- ☐ Lying/exaggeration
- ☐ Manipulative
- ☐ Memory problems
- ☐ Mood swings
- ☐ Moodiness
- ☐ Motivation
- ☐ Money management
- ☐ Mute, refuses to speak
- ☐ Negativity
- ☐ Nightmares/night terrors
- ☐ Obesity
- ☐ Obsessions, compulsions
  (thoughts or actions that repeat themselves)
- ☐ Oppositional/defiant
- ☐ Organization
- ☐ Overly sensitive
- ☐ Overly obedient
- ☐ Over sensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ People pleaser
- ☐ Perfectionist
- ☐ Pessimism
- ☐ Phobias
- ☐ Poor self care
- ☐ Procrastination
- ☐ Productivity problems
- ☐ Prone to injury
- ☐ Relationship problems
- ☐ Reluctance to go to school/work
- ☐ Responsible
- ☐ Restlessness
- ☐ Rituals (has to repeat same action)
- ☐ Rocking or repetitive movements/gestures
- ☐ Rule breaking
- ☐ Sadness
- ☐ School refusal
- ☐ Self-centered
- ☐ Self control
- ☐ Self-destructive behaviors
- ☐ Self-esteem
- ☐ Self-harm
- ☐ Sexual issues
- ☐ Shyness
- ☐ Sleep disturbances
- ☐ Social isolation/withdrawal
- ☐ Steals
- ☐ Stress management issues
- ☐ Suicidal thoughts
- ☐ Suicide talk/attempt
- ☐ Suspicious, distrustful
- ☐ Talks back
- ☐ Teases others unmercifully
- ☐ Temper problems
- ☐ Thought disorganization and confusion
- ☐ Thoughts of death/dying
- ☐ Threats, violence
- ☐ Thumb sucking
- ☐ Tics
- ☐ Time management issues
- ☐ Wets bed/clothes
- ☐ Which of these is primary or most pressing?

_____

_____

_____

_____