INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name:_____ Date of Birth: _____

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment). I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with your provider any questions or concerns you may have.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(for minor)

INFORMED CONSENT & THERAPY CONTRACT

As a client, it is important that you are fully informed about the services you will receive. Your signature below indicates that you have been informed of the policies of this Provider and you are making an informed decision about entering therapy.

1. I understand that my therapist is an Independent Provider licenses in the State of Kansas to diagnose and treat mental disorders.

2. I understand that my provider is bound by the Code of Ethics ser forth by that Provider's professional association and that I can request a copy of those ethics at any time.

3. I understand that, as a client, I have certain rights and those rights have been reviewed with me by the provider.

4. I understand that, excepts under circumstances mandated by law, communications with Provider will remain confidential as will any records regarding the therapy process unless I sign an Authorization & Request for Release of Confidential Information and Privileged Communication Form authorizing access to the information before any file information will be released in accordance with K.S.S. 65-6410. If more than one family member participates in a session, each and every family member must consent prior to the release of the file information. Where a minor is receiving services, the appointment of a guardian ad litem may be necessary to the release of the minor client's information. The client's family members are not entitled access to client information just because they are family.

5. I understand that, in accordance with state regulation and/or professional ethics, specific circumstances require the Provider to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when: a) A Provider believes a client may be and danger to him or herself or to others; b) The Provider believes that a child, elderly, or disabled person may be subject to abuse or neglect; and c) When are court order exists that information regarding the therapy process be provided.

6. I understand that, if the Provider or client records are subpoenaed to court on my behalf, I may be responsible for charges associated with time spent by the Provider to prepare and furnish these records and/or appear in court.

7. I understand that, under Kansas Law, the Provider is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete a Release of Information form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time if I so request.

8. I understand that there can be risks and benefits associated with therapy and have discussed those with the Provider.

9. I have read and understand the Technology Policies of the Provider and agree to abide by them.

10. To promote and environment which is safe and free of violence, the possession and/or use of dangerous weapons on site is prohibited. By signing below, you agree that you will abide by this policy.

11. I understand the financial policies or the therapy site and agree to pay $_____ for each therapy session.

12. I agree that if I need to cancel or reschedule and appointment that I will let the Provider know 24 hours in advance of the appointment, and that if I do not do so, I may be responsible for cancellation fees.

13. I acknowledge that I have received and been given opportunity to review this Providers *Privacy Notice to Clients.*

My signature below indicates that I give my full and informed consent to receive therapy services from this Provider.

Client Signature	Date	Client Signature	Date
Client Signature	Date	Client Signature	Date
Client Signature	Date	Client Signature	Date
Therapist Signature C.L. Foos LSCSW	Date	Therapist Signature C.L. Foos LSCSW	Date

FINANCIAL POLICIES

1. **FEES.** The fees for therapy are as follows: $130.00 per 45-53 minute session; $150.00 per 54-60 minute session; $185.00 per 61-75 minute session and $220.00 per 76-89 minute session. The fee may be adjusted as per contractual agreement with the client's insurance company, the Crime Victims' Compensation Board, SAS, or with the therapist. The fee is to be paid at the end of each therapy session.

2. **NO SHOW AND CANCELLATION POLICY.** Notice of cancellation is appreciated 24 hours in advance of a scheduled session so that someone else may be offered the time you cannot take. If you have not cancelled your appointment before the hour you will be charge $65.00. exceptions apply to certain EAPS and Medicaid. The charge must be paid prior to or at the client's next session. Other exceptions, e.g., due to emergencies, will be made at the discretion of the therapist.

3. **TELEPHONE CALLS.** After-hour telephone calls for other than scheduling purposes may be billed at the established hourly fee. An additional charge of $10.00 will be billed to the client for long distance telephone call made for the purpose of consultation.

4. **COURT.** The client will be charged the rate of $150.00 per hour for the time incurred by the therapist to prepare for and to appear in court or any legal proceeding concerning the client. This will also include travel time. Out of town appearances will be charged a minimum of $500.00 plus any additional time. If court is cancelled less than 24 hours in advance, the client will be charged the time the therapist reserved for court.

5. **REPORTS.** The client will be charged $150.00 per page to prepare written reports for the court or other evaluation purposes. Additional charges may be incurred if excessive review of records and/or collateral contacts are required. The client's account must be paid in full before the report or evaluation is provided.

6. **RETURNED CHECKS.** The client will be charged a $25.00 administration fee on checks returned due to insufficient funds and will be required to pay cash for any future sessions.

7. **INSURANCE.** [redacted] will file insurance claims for those clients who are eligible for reimbursement. Clients are responsible for providing billing information and a copy of their insurance care. **In addition, clients are responsible for reviewing and knowing their out-patient mental benefits.**

8. **PAYMENTS.** The client is responsible for the payment of amounts not covered by their insurance plan. These amounts can include plan deductible, co-insurance or co-pays, and charges for services not covered by insurance, i.e., court appearances, depositions, reports/evaluation, etc. Please pay deductibles, co-pays or co-insurance at the time of each session.

9. **COLLECTIONS.** All accounts with unpaid balances over 90 days past due will be referred to a collection agency and/or an attorney. A charge of $15.00 and 18% interest on the unpaid balance will be assessed on accounts that are turned over to a collection agency. In addition, attorneys' fees and courts costs will be added to delinquent accounts that are turned over for collection.

10. **FINANCE CHARGE.** A finance charge of 1.5% per month (18% per year) will be applied to unpaid balances carried over to the next statement.

11. **CONSENT TO BILL.** By the clients signature below, we are authorized to disclose:

    (a) Confidential diagnostic and treatment information, including medical records, to the client's insurance company for the purpose of submitting claims on behalf of the client. Furthermore, the Center is authorized to receive any and all payments made by the insurance company directly to the Center and/or to the client for services rendered and chargers submitted; and, (b) The client's name, address, phone number, and other relevant financial information to a collection agency, attorney, or to the court for the purpose of attaining reimbursement of services provided.

    I hereby consent to the fees and policies as set out above. I agree to 1. Use my insurance, 2. Use my EAP sessions, or 3. Pay a self-pay fee in the amount of $70.00/session.

Responsible Party _____ Date _____

Therapist C. J. Foos LSCSW Date _____

Date:

Client, _____, gives Christy L. Foos, LSCSW, LCAC and DOT Substance Abuse Professional permission to use electronic devices to conduct DOT SAP Evaluations and any other form of modality to evaluate and or treatment me. This includes but does not limit, phone calls, emails, texting, ICANotes, VSee, messenging, Zoom and any other non HIPPA compliant devise or electronic program. I acknowledge she will do her best due deligience to keep my information private and only devouge what is necessary to people involved in the coordination of my care and or pertaining to the DOT SAP process.

Signature of Client: _____ Date:_____

Signature of Clinician: C. L. Foos LSCSW Date:_____

Date:

Due to the public health emergency COVID-19 in effect at this time, I, Christy L. Foos, LSCSW, LCAC and DOT Substance Abuse Professional conducted this client's initial assessment and the follow-up evaluation by using ICANOTES electronic health record system obtaining all paperwork via HIPPA compliant software and via VSEE virtual messaging and video conference which is HIPPA compliant. Further, a Permission to utilize electronic software and video conferencing equipment/technology was approved by the client.

Signature of Client: _____ Date:_____

Signature of Clinician: C. L. Foos LSCSW Date:_____

CLIENTS' RIGHTS

1. Clients may prevent the center from disclosing to anyone the fact that they have been previously or are currently receiving any type of mental health treatment. This confidentiality includes anything the client has said provided to the Center staff during any process of consultation, assessment, and/or treatment.

2. The client's rights or confidentiality shall automatically be claimed on behalf of a client by the Center unless the client expressly waives the privilege in writing. In circumstances where more than one person in a family receives therapy, each such family member who is legally competent to execute a waiver must do so in order for a therapist to disclose information received from any family member.

3. The Center is not obligated to release records that the therapist believes may be injurious to the client.

4. The Center's staff will not disclose client confidences, as set out above except: (a) as mandated by K.S.A. 38-1552 which includes all cases of suspected child abuse or involvement of a child in a crime in the past or present, (b) as mandated by K.S.A 39-1430 which involves the protection of adults over the age of 18 who are unable to provide this protection for themselves, (c) to prevent a clear and immediate danger to a person or persons, and (d) per order of the court.

5. The Center's medical consultant and other professional approved supervisors periodically review the client's progress with the therapist. By signing this form, the client authorizes disclosure of treatment information for supervisory purposes only.

6. Clients are entitled to an explanation of the nature of any course of treatment prescribed, the reason for such treatment, and any know risks associated with such treatment.

7. Clients have the right to refuse any prescribed treatment. In addition, clients must give their written permission to be videotaped or audio taped prior to the therapist doing so.

8. Clients have the right to terminate therapy at any time. Furthermore, the Center's staff will continue therapy only so long as it is reasonably clear that clients are benefiting from participation in therapy.
9. Should a therapist be unable or unwilling, for appropriate reasons, to provide professional help to a client, the therapist will assist the person to obtain therapeutic service.

10. The Center don't not discriminate against or refuse professional service to anyone on the bases of race, gender, religion, national origin, or sexual orientation.

I acknowledge by my signature below that I have read the above information, understand its content, and consent to assessment and/or treatment:

Client/Parent/Guardian	Date
Client/Parent/Guardian	Date
Client	Date
Client	Date
Therapist C. L. Foos LSCSW	Date

CONSENT TO E-COMMUNICATION

You have a choice about how you communicate with your therapist. Text messaging and e-mail are non-secure forms of communication. This means that these forms of communication are not encrypted and may be accessed by third parties.

It is our policy that therapeutic issues not be discussed at length over text message or email. Discussion regarding therapeutic issues should be limited to scheduled therapy sessions.

Please initial below next to your preference regarding communication with your therapist:

_____ I understand the risk involved with e-mail or text messaging my therapist (that these are non-secure forms of communication) and give my consent to communicate with him or her in the following ways:

_____Text message (preferred phone number: _____)

_____ Email (preferred e-mail: _____)

_____ I do not wish to receive text messaged or e-mails from my therapist. I understand and agree that the therapist will only contact me by telephone (voice call)

_____ _____

Client Signature Date

NOTICE OF PRIVACY PRACTICES

Effective April 29, 2015

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how your provider may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), your provider is required to maintain the privacy of PHI and to provide you with notice of his or her legal duties and privacy practices with respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your provider reserves the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

HOW YOUR PROVIDER MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization.

For Payment: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only disclose the minimum amount of PHI necessary for purposes of collection will be disclosed.

For Health Care Operations: Your provider may use or disclose, as needed, your PHI in order to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be used to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, your provider must make disclosures of your PHI to you upon your request. In addition, disclosures must be made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations.
- Required by Court Order

- Necessary to prevent or lessen a serious an imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: Your provider may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider:

Right of Access to Inspect and Copy. In most cases, you have the right to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Your provider may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI your provider has about you is incorrect or incomplete, you may ask for it to be amended, although your provider is not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that your provider makes of your PHI. Your provider may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. Your provider is not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that your provider communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of This Notice. You may ask your provider for a paper copy of this notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with the Federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the Federal Government, contact:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways my provider may use or disclose personal health information to provide service.

Client Name: _____ Client Signature: _____

Date: _____

If signed by other than client, indicate relationship:

_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this form is to authorize Christy L. Foos, LSCSW *("The Provider") to share protected information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled "Restriction on Disclosure." Otherwise, please complete the form as indicated.*

CLIENT:

Last Name _____ First Name _____ MI _____ Date Of Birth _____

THIRD PARTY:

Organization/Individual Name _____

Address _____ Telephone/Fax _____

I authorize the Provider to (check all that apply)

☑ Release to ☐ Obtain from ☑ Discuss with

The third party identified above the specified protected health information listed below for purposes of treatments, payment, and health care operations. "This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding threat the consent will continue to unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given under 42 CFR Part 2, Federal Resister, Volume 52-Number 110, June 9, 1987, shall have a duration of no longer than that reasonably necessary to effectuate the purpose for which it is given. Notice to clients: This release form is also compliant with 45 CFR Parts 160 to 164. "

PLEASE INITIAL EACH APPLICABLE ITEM:

_____ Admission Evaluation Report
_____ Diagnosis Only
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ Psychological Evaluation Report
_____ Discharge Summary
_____ Progress Review(s)
_____ Alcohol and Drug Treatment Information
_____ Hospitalization Screening
_____ Medical Reports
_____ Coordination of Care
_____ HIV/AIDS Information
___ Progress Notes from _____ to _____
_____ Legal Reports
_____ Education Reports
___ Other: _____

This authorization shall remain in effect until _____ (date) at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below,

I understand that enrollment, eligibility, payment, or treatment is no conditioned upon the authorization. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to the Provider.

"Prohibition on Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

X **Print Name and Date:** _____ X **Parent Guardian Print Name and Date:** _____

X **Client Signature and Date:** _____ X **Parent Guardian Signature and Date:** _____

Witnessed Signature, Credentials and Date: C. L. Foos, LSCSW, LCAC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this form is to authorize Christy L. Foos, LSCSW *("The Provider") to share protected information with the Identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled "Restriction on Disclosure." Otherwise, please complete the form as indicated.*

CLIENT:

Last Name _____ First Name _____ MI _____ Date Of Birth _____

THIRD PARTY:

Organization/Individual Name _____

Address _____ Telephone/Fax _____

I authorize the Provider to (check all that apply)

☑ Release to ☑ Obtain from ☑ Discuss with

The third party identified above the specified protected health information listed below for purposes of treatments, payment, and health care operations. "This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding threat the consent will continue to unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given under 42 CFR Part 2, Federal Register, Volume 52-Number 110, June 9, 1987, shall have a duration of no longer than that reasonably necessary to effectuate the purpose for which it is given. Notice to clients: This release form is also compliant with 45 CFR Parts 160 to 164. "

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_____ Medical Reports
_____ Coordination of Care
_____ HIV/AIDS Information
___ Progress Notes from_____to_____
_____ Legal Reports
_____ Education Reports
___ Other:_____

This authorization shall remain in effect until_____(date) at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below,

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X **Print Name and Date:** _____ X **Parent Guardian Print Name and Date:** _____

X **Client Signature and Date:** _____ X **Parent Guardian Signature and Date:** _____

Witnessed Signature, Credentials and Date: C. L. Foos, LSCSW, LCAC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this form is to authorize Christy L. Foos, LSCSW ("The Provider") to share protected information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled "Restriction on Disclosure." Otherwise, please complete the form as indicated.

CLIENT:

Last Name _____ First Name _____ MI _____ Date Of Birth _____

THIRD PARTY:

Organization/Individual Name _____

Address _____ Telephone/Fax _____

I authorize the Provider to (check all that apply)

[i] Release to [i] Obtain from [✓] Discuss with

The third party identified above the specified protected health information listed below for purposes of treatments, payment, and health care operations. "This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding threat the consent will continue to unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given under 42 CFR Part 2, Federal Register, Volume 52-Number 110, June 9, 1987, shall have a duration of no longer than that reasonably necessary to effectuate the purpose for which it is given. Notice to clients: This release form is also compliant with 45 CFR Parts 160 to 164. "

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_____ Medical Reports
_____ Coordination of Care
_____ HIV/AIDS Information
___ Progress Notes from _____ to _____
_____ Legal Reports
_____ Education Reports
___ Other: _____

This authorization shall remain in effect until _____ (date) at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below,

I understand that enrollment, eligibility, payment, or treatment is no conditioned upon the authorization. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to the Provider.

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X Print Name and Date: _____ Parent Guardian Print Name and Date: _____

X Client Signature and Date: _____ Parent Guardian Signature and Date: _____

Witnessed Signature, Credentials and Date: C. L. Foos, LSCSW, LCAC

Patient Name:_____ Date:_____

The Michigan Alcoholism Screening Test (MAST)

Please circle either Yes or No for each item as it applies to you.

1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	Yes	No
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes	No
3. Does your wife, husband, a parent , or other near relative ever worry or complain about your drinking?	Yes	No
4. Can you stop drinking without a struggle after one or two drinks?	Yes	No
5. Do you ever feel guilty about your drinking?	Yes	No
6. Do friends or relatives think you are a normal drinker?	Yes	No
7. Are you able to stop drinking when you want to?	Yes	No
8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	Yes	No
9. Have you gotten into physical fights when drinking?	Yes	No
10. Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	Yes	No
11. Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	Yes	No
12. Have you ever lost friends because of drinking?	Yes	No
13. Have you ever gotten into trouble at work or school because of drinking?	Yes	No
14. Have you ever lost a job because of drinking?	Yes	No
15. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Yes	No
16. Do you drink before noon fairly often?	Yes	No
17. Have you ever been told you have liver trouble? Cirrhosis?	Yes	No
18. After heavy drinking have you ever had Delirium Tremens (D.T.'S) or severe shaking, or heard voices or seen things that really were not there?	Yes	No
19. Have you ever gone to anyone for help about your drinking?	Yes	No
20. Have you ever been in a hospital because of drinking?	Yes	No
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	Yes	No
22. Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem?	Yes	No
23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times? _____)	Yes	No
24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? (If YES, how many times? _____)	Yes	No

Scoring the MAST

The version of the MAST included on this web site was provided by Professor Selzer, who indicated that the version published in 1971 in the American Journal of Psychiatry was modified in 1980.

In scoring the MAST points are assigned to a response depending upon whether the item is worded positively or negatively.

For items 1, 4, 6 and 7 negative answers are consistent with alcoholic responses.

For items 2, 3, 5, and 9-25 positive responses are consistent with alcoholic responses.

The scale assigns a 1-5 weighting to each of the items, with a rating of 5 being considered diagnostic of alcoholism. Questions that were highly discriminating were given a value of two points and others assigned a one-point value. An alcoholic response to questions 8, 19, or 20 is considered diagnostic and is assigned a value of five points.

A total score is computed as a sum of item values as seen in the table below. Total scores range from 0 to 53.

MAST Point System

Question	Points Assigned
1. (negative responses are alcoholic)	2
2.	2
3.	1
4. (negative responses are alcoholic)	2
5.	1
6. (negative responses are alcoholic)	2
7. (negative responses are alcoholic)	2
8.	5
9.	1
10.	2
11.	2
12.	2
13.	2
14.	2
15.	2
16.	1
17.	2
18.	2
19.	5
20.	5
21.	2
22.	2
23.	2
24.	2

Citation: Selzer ML: The Michigan Alcoholism Screening test (MAST): the quest for a new diagnostic instrument. American Journal of Psychiatry 3:176-181, 1975

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Drug Abuse Screening Test (DAST-10)

General Instructions

"Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Segment: _ _

Visit Number: _ _

Date of Assessment: (mm/dd/yyyy) _ _/_ _/_ _ _ _

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. **Have you used drugs other than those required for medical reasons?**
   ☐No ☐Yes

2. **Do you use more than one drug at a time?**
   ☐No ☐Yes

3. **Are you always able to stop using drugs when you want to?**
   ☐No ☐Yes

4. **Have you had "blackouts" or "flashbacks" as a result of drug use?**
   ☐No ☐Yes

5. **Do you ever feel bad or guilty about your drug use?**
   ☐No ☐Yes

6. **Does your spouse (or parents) ever complain about your involvement with drugs?**
   ☐No ☐Yes

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371.
Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. J Subst Abuse Treatment. 32:189-198.

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7. **Have you neglected your family because of your use of drugs?**

☐No ☐Yes

8. **Have you engaged in illegal activities in order to obtain drugs?**

☐No ☐Yes

9. **Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?**

☐No ☐Yes

10. **Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?**

☐No ☐Yes

Comments:

Scoring

Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.

DAST Score: _ _

Interpretation of Score:

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371.
Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. J Subst Abuse Treatment. 32:189-198.

CAGE Alcohol Abuse Screening Tool

The CAGE questionnaire, the name of which is an acronym of its four questions, is a widely used screening test for problem drinking and potential alcohol problems (alcoholism).

Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

C	Have you ever felt the need to **cut** down on your drinking?	Yes	No
A	Have people **annoyed** you by criticizing your drinking?	Yes	No
G	Have you ever felt **guilty** about drinking?	Yes	No
E	Have you ever felt you needed a drink first thing in the morning (**Eye-Opener**) to steady your nerves or to get rid of a hang over?	Yes	No

Interpreting the CAGE Screening Tool

Two "yes" responses indicate that the possibility of alcoholism should be investigated further.

The CAGE questionnaire, among other methods, has been extensively validated for use in identifying alcoholism. CAGE is considered a validated screening technique, with one study determining that CAGE test scores ≥2 had a specificity of 76% and a sensitivity of 93% for the identification of excessive drinking and a specificity of 77% and a sensitivity of 91% for the identification of alcoholism.

By far the most important question in the CAGE questionnaire is the use of a drink as an Eye Opener, so much so that some clinicians use a "yes" to this question alone as a positive to the questionnaire; this is because the use of an alcoholic drink as an Eye Opener connotes dependence since the patient is going through possible withdrawal in the morning, hence the need for a drink as an Eye Opener.

References

Ewing, John A. "Detecting Alcoholism: The CAGE Questionnaire" JAMA 252: 1905-1907, 1984 PMID 6471323
"CAGE Substance Abuse Screening Tool" (PDF). Johns Hopkins Medicine. Retrieved 30 July 2014.
Kitchens JM (1994). "Does this patient have an alcohol problem?". JAMA 272 (22): 1782–7. doi:10.1001/jama.1994.03520220076034. PMID 7966928.
Bernadt, MW; Mumford, J; Taylor, C; Smith, B; Murray, RM (1982). "Comparison of questionnaire and laboratory tests in the detection of excessive drinking and alcoholism". Lancet 6 (8267): 325–8. doi:10.1016/S0140-6736(82)91579-3. PMID 6120322.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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
☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column		+	+	+
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Substance Type	Method of Use	Age of first use	Frequency (How often)	Amount (How much)	Last use	Longest period of abstinent	What are you like under the influence	Have you ever experienced withdrawals	Do you have craving	Has it caused you trouble with the law
Example: Whiskey:Vodka	Oral	25	Weekly	1 pt.	08/08/2009	20 years	funny, talkative	Shakes, vomiting	No	1 DUI 2009 1 DUI 2007
Beer										
Whiskey										
Marijuana (Hashish, hash oil, Sativex)										
Stimulants (meth, cocaine)										
Depressants (Xanax, Valium)										
Hallucinogens (LSD, Psilocybin)										
Dissociatives (Ketamine, PCP)										
Opioids (Heroin, Oxycontin)										
Inhalants (Room Deo., Nitrous Oxide)										
Other										
Tobacco										

How many times in Treatment?

Thoughts of Suicide or Homicide under the influence?

Does it cause issue with your family, finances, legal issues, friends, employment? Please specify and explain?

Can you stop drinking on your own?