

CLIENT CONFIDENTIALITY STATEMENT

Therapist Signature: _____ Date: _____

Client Name:
SoonerCare ID:

Byte and Associates, LLC Counseling Services
Individual Consent - Consent to the Use and Disclosure of Individually Identifiable
Health Information for Treatment, Payment, and/or Health Care Operations

I understand that as a part of my health care, Byte & Associates, LLC, receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examinations, and test results, diagnoses, treatment, treatment plans, and billing and health information. I understand that Byte & Associates, LLC, and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my psychiatric/psychological condition
- Plan my care and treatment
- Communicate with other health professionals concerning my care
- Document services for payment/reimbursement
- Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

I have been provided a *Notice of Information Practices* that fully explains the uses and disclosures that Byte & Associates, LLC will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent. Byte & Associates, LLC has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also understand that Byte & Associates, LLC cannot use or disclose my individually identifiable information other than as specified on the *Notice*. I also understand, however, that Byte & Associates, LLC reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised *Notice* to the address that I have provided.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, Byte & Associates, LLC may refuse to provide me health care services unless applicable state or federal law requires Byte & Associates, LLC to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that Byte & Associates, LLC is not required to agree to the requested restrictions but that, if it does agree, it must honor the restriction unless I request that it stop doing so or Byte & Associates, LLC notifies me that it is no longer going to honor the request.

I request the following restrictions on the use or disclosure of my individually identifiable health information:

I understand that I have the right to request restriction as to the method of communication to me. For example, I might request that all behavioral health information be mailed to a certain post office box rather than to my home. I further understand that Byte & Associates, LLC must honor this request if the *method of communication* would harm me if I want an alternate method of communication.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for facility directories and to family members. I object to uses and disclosures as follows:

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Byte & Associates, LLC has already taken action in reliance on my earlier effective consent.

The information you authorize to release may include records that may indicate the presence of a communicable or venereal disease, which may include, but are limited to, disease such as hepatitis, syphilis, gonorrhea, tuberculosis, and the human immunodeficiency virus (HIV) also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature of Patient or Legal Representative

Signature of Witness

Date

Sooner Care #: _____

Every adult who is under the care of a licensed mental health professional shall have the right to designate a family member or other concerned individual as a treatment advocate. The individual designated as a treatment advocate shall act at all times in the best interests of the consumer. The designation of treatment advocate may be changed or revoked at any time for any reason. The treatment advocate may participate in the treatment planning and discharge planning of the consumer to the extent consented to by the consumer and as permitted by law. A person holding the powers vested in a guardianship of the person, a grant of general health care decision-making authority or designation of health care proxy contained in an advance directive for health care, or a durable power of attorney with a health care decision-making authority shall be the treatment advocate for the patient by operation of law.

Date Revoked: _____ by: _____

Client Name:
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ACE: Adverse Childhood Experience

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**...

Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...

Touch or fondle you or have you touch their body in a sexual way?

or

Attempt or actually have oral, anal, or vaginal intercourse with you?

Yes No If yes enter 1 _____

4. Did you **often or very often** feel that ...

No one in your family loved you or thought you were important or special?

or

Your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you **often or very often** feel that ...

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?

Yes No If yes enter 1 _____

7. Was your mother or stepmother:

Often or very often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

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DASS: Depression Anxiety Stress Scale

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all.
- 1 Applied to me to some degree, or some of the time.
- 2 Applied to me to a considerable degree, or a good part of time.
- 3 Applied to me very much, or most of the time.

PLACE "X" UNDER YOUR ANSWER	0	1	2	3	
1. I found myself getting upset by trivial things					S
2. I was aware of dryness of my mouth					A
3. I couldn't seem to experience any positive feelings at all					D
4. I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)					A
5. I just couldn't seem to get going					D
6. I tended to over-react to situations					S
7. I had a feeling of shakiness (eg, legs going to give way)					A
8. I found it difficult to relax					S
9. I found myself in situations that made me so anxious I was most relieved when they ended.					A
10. I felt that I had nothing to look forward to					D
11. I found myself getting upset rather easily					S
12. I felt that I was using a lot of nervous energy					S
13. I felt sad and depressed					D
14. I found myself getting impatient when I was delayed in any way (eg. Lifts, traffic lights, being kept waiting)					S
15. I had a feeling of faintness					A
16. I felt that I had lost interest in just about everything					D
17. I felt I wasn't worth much as a person					D
18. I felt that I was rather touchy					S
19. I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion					A
20. I felt scared without any good reason					A
21. I felt that life wasn't worthwhile					D
22. I found it hard to wind down					S

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23. I had difficulty in swallowing					A
24. I couldn't seem to get any enjoyment out of the things I did					D
25. I was aware of the action of my heart in the absence of physical exertion (eg. Sense of heart rate increase, heart missing a beat)					A
26. I felt down-hearted and blue					D
27. I found that I was very irritable					S
28. I felt I was close to panic					A
29. I found it hard to calm down after something upset me					S
30. I feared that I would be "thrown" by some trivial but unfamiliar task					A
31. I was unable to become enthusiastic about anything					D
32. I found it difficult to tolerate interruptions to what I was doing					S
33. I was in a state of nervous tension					S
34. I felt I was pretty worthless					D
35. I was intolerant of anything that kept me from getting on with what I was doing					S
36. I felt terrified					A
37. I could see nothing in the future to be hopeful about					D
38. I felt that life was meaningless					D
39. I found myself getting agitated					S
40. I was worried about situations in which I might panic and make a fool of myself					A
41. I experienced trembling (eg, in the hands)					A
42. I found it difficult to work up the initiative to do things					D

S _____

A _____

D _____

Total: _____

	Depression (D)	Anxiety (A)	Stress (S)
Normal	0 – 9	0 – 7	0 – 14
Mild	10 – 13	8 – 9	15 – 18
Moderate	14 – 20	10 – 14	19 – 25
Severe	21 – 27	15 – 19	26 – 33
Extremely Severe	28+	20+	34 +

Gambling

Initial here if this does not apply _____

1. Have there ever been periods lasting two weeks or longer when you spent a lot of time thinking about your gambling experiences, planning out future gambling ventures or bets, or thinking about ways of getting money to gamble with?*

☐ Yes

☐ No

2. Have there ever been periods when you needed to gamble with increasing amounts of money or with larger bets than before in order to get the same feeling of excitement?*

☐ Yes

☐ No

3. Have you ever felt restless or irritable when trying to stop, cut down, or control your gambling?*

☐ Yes

☐ No

4. Have you tried and not succeeded in stopping, cutting down, or controlling your gambling three or more times in your life?*

☐ Yes

☐ No

5. Have you ever gambled to escape from personal problems, or to relieve uncomfortable feelings such as guilt, anxiety, helplessness, or depression?*

☐ Yes

☐ No

6. Has there ever been a period when, if you lost money gambling one day, you would often return another day to get even?*

☐ Yes

☐ No

7. Have you lied to family members, friends, or others about how much you gamble, and/or about how much money you lost on gambling, on at least three occasions?*

☐ Yes

☐ No

8. Have you ever written a bad check or taken money that didn't belong to you from family members, friends, or anyone else in order to pay for your gambling?*

☐ Yes

☐ No

9. Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends? Or, has your gambling ever caused you problems at work or your studies?*

☐ Yes

☐ No

10. Have you ever needed to ask family members, friends, a lending institution, or anyone else to loan you money or otherwise bail you out of a desperate money situation that was largely caused by your gambling?*

☒ Yes

☐ No

Client Name:
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DAST- 10

Drug Alcohol Screening Test

Initial here if this does not apply _____

You are going to read a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

PLACE “X” UNDER YOUR ANSWER		NO	Score	YES	Score
1.	Have you used drugs other than those required for medical reasons?		0		1
2.	Do you abuse more than one drug at a time?		0		1
3.	Are you always able to stop using drugs when you want to? (If never use drugs, answer “Yes.”)		1		0
4.	Have you had "blackouts" or "flashbacks" as a result of drug use?		0		1
5.	Do you ever feel bad or guilty about your drug use? If never use drugs, choose “No.”		0		1
6.	Does your spouse (or parents) ever complain about your involvement with drugs?		0		1
7.	Have you neglected your family because of your use of drugs?		0		1
8.	Have you engaged in illegal activities in order to obtain drugs?		0		1
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		0		1
10.	Have you had medical problems as a result of your drug use (eg. memory loss, hepatitis, convulsions, bleeding, etc.)?		0		1

STOP DO NOT GO BEYOND THIS PAGE.

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DAST-10 SCORING

In these statements, the term "drug abuse" refers to the use of medications at a level that exceeds the instructions, and/or any non-medical use of drugs. Patients receive 1 point for every "yes" answer with the exception of question #3, for which a "no" answer receives 1 point. DAST-10 Score Degree of Problems Related to Drug Abuse Suggested Action.

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

SCORING CHECKLIST

_____ PED. SYMPTOM
 _____ CATS
 _____ ACE
 _____ DASS
 _____ DAST10