Over the Rainbow Psychotherapy, PLLC
Cynthia Denise Porter, LPC-S
1520 West Dove Avenue, Suite B
McAllen, Texas 78504

COUPLE INFORMED CONSENT AND RELEASE OF INFORMATION SIGNATURE PAGE

DATE _____ NAME _____ DOB _____

FORMS RECEIVED in the "Couple Information Packet"

1. I have received the "Practice Welcome Letter (revised 11-15-15) which outlines my therapist's educational background, licensure, experience, usual treatment methods and treatment philosophy. (Page 1)
2. I have received the "Couples Therapy Information Notice 11-15-15" (Page 2 and 3)
3. I have received the "Financial Policies Notice revised 11-15-15 (pages 4 and 5)
4. I have received the "Emergency Procedures Information /Appointment Protocol Notice revised 11-15-15." (Page 6)
5. I have received the "Confidentiality Notice revised 11-15-15" (Page 7 and 8)
6. I have received the notice entitled, "Client Rights Notice revised 11-15-15 (Page 9)
7. I have received the "Notice of Privacy Practices revised 11-15-15." (Pages 10,11,12, 13)
8. I have received the notice entitled, "What to Expect from Your Licensed Professional Counselor" (Pages 14 and 15)

ACKNOWLEDGEMENTS

I, authorize, Cynthia Denise Porter, LPC- S/Over the Rainbow Psychotherapy, PLLC to provide couples therapy. The Clients and the therapist agree that if the counseling terminates, the therapist not be called as a witness by either client in any future litigation between the Clients. The Clients and the therapist further agree that, if couple's counseling terminates, the therapist may not be further consulted by either client, unless the Clients reinstitute the couples counseling process.

I certify (if applicable) that I (or my dependent) have insurance coverage. I hereby assign directly to Over the Rainbow Psychotherapy, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature to authorize treatment and consent on all insurance submissions.

I acknowledge that I have received the notices and brochures outlined above. I have reviewed or have had the opportunity to review them and to ask questions. I have also had the opportunity to ask questions about my therapist and my treatment. I agree to abide by these terms and policies of Over the Rainbow Psychotherapy, PLLC. I also understand that these terms may be amended from time to time by Over the Rainbow Psychotherapy, PLLC.

_____	_____	_____
Client Name (Print)	Signature	Date
_____	_____	_____
Client Name (Print)	Signature	Date

Over The Rainbow Psychotherapy, PLLC

Cynthia Denise Porter, LPC-S

Revised 07-25-2016

HEALTHCARE PROVIDERS RELEASE FORM

INSTRUCTIONS:

Communication and collaboration among your healthcare providers is essential for the delivery of integrated quality care. In fact, many managed care companies require that we have interaction with your primary care physician and your psychiatrists. If you give us consent to discuss your clinical information and treatment with your doctor/s, please complete the form below. If you don't have a physician or psychiatrist, write "NONE" on the Dr's name line and if you refuse to allow us to contact your physician or psychiatrist, write "REFUSED" in those lines. Please sign and date the form, whatever your choice. Please be sure to include PHONE numbers including FAX numbers to your form to ensure proper processing.

I _____(DOB) _____, authorize Cynthia Denise Porter, LPC-S / Over The Rainbow, PLLC to disclose to and receive information from my primary care physician, Dr._____whose practice is in (city) _____(phone number)_____(fax) number_____and from my psychiatrist, Dr. _____whose practice is in (city)_____(phone number)_____(fax number)_____about my applicable behavioral health or substance abuse information including the diagnosis, treatment planning, and medications. This consent is effective from the date below until revoked.

_____

Patient signature

_____

Date

Over the Rainbow Psychotherapy, PLLC
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Credit Card Preauthorization Form
Revised 11-15-15

To serve you better, we ask that all clients complete a preauthorization application, providing a credit or debit card to pay for any account balances. Unpaid balances will be automatically transferred to your credit or debit card. Payment of balances is required before any new appointment can be made.

I authorize Over the Rainbow Psychotherapy, PLLC to keep my signature on file and to charge my credit/debit card for

any service/s provided to _____
First and last name of person receiving services
as specified below:

No-shows and late cancellations (without 24 hour notice) will be charged a $50.00 fee as outlined in the "Financial Policies Handout."
Co-pays/deductibles not paid at time services were rendered.
Fees for non-covered services.
Fees for services not paid for by guardian, parent or patient's insurance within 90 days.
Date/s of service to be covered range from the first date of service to the last date of service.

I understand that this form is valid until I cancel the authorization through written notice to Over the Rainbow Psychotherapy, PLLC.

_____ _____
Cardholder Signature Date

Please fill out all information below

Patient name _____

Cardholder name as it appears on the card _____

Cardholder billing address _____

_____
City State Zip

(Check one) _____ Visa _____ Master Card _____ Debit Card

Credit Card Number _____ CV# _____

Expiration Date _____

Over the Rainbow Psychotherapy, PLLC
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Instructions: Each partner should answer the following assessments (the PHQ9, GAD 7, CAGE-AID and Partner Questionnaire) separately. Be sure to put your names and Date of Birth on the forms.

Over the Rainbow Psychotherapy, PLLC
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Partner #1 Name:_____ DOB: _____

PHQ-9 Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Circle number 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 eating……	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

Columns Totals ____ + ____ + ____ + ____

= Total Score _____

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Partner #1 Name:_____ DOB: _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
(Circle number to indicate your answer)				
1. Feeling nervous, anxious or on the 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 is 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
Column totals:	+	+	+	
	___	____	____	____

= Total Score _____

If you circled 1 -3 on any items above, 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**
□	□	□	□

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Partner #1 Name:_____ DOB: _____

CAGE-AID QUESTIONNAIRE

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Please circle your answer.

Questions:

1. Have you ever felt that you ought to cut down on your drinking or drug use?
   YES NO

2. Have people annoyed you by criticizing your drinking or drug use?

   YES NO

3. Have you ever felt bad or guilty about your drinking or drug use?

   YES NO

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

   YES NO

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PARTNER QUESTIONNAIRE

Partner #1 Name:_____

Date:_____

Directions: Each partner needs to fill out this questionnaire separately.

1. What is the problem that led you to decide to come to therapy?

2. How long have you and your partner been together?_____

3. In what form (i.e., dating, living together, married)? _____

4. How was the decision to live together or marry made?

5. What was the very beginning of your relationship like?

How long did this phase last?

6. What was your first disillusionment?

What happened and how did you resolve it?

Did this lead to any changes in your relationship?

7. When did you first become aware of significant differences between the two of you?

How are the two of you similar?

How are you different?

8. What do you do when there is conflict between the two of you?

What does your partner do?

9. What do you do when you are angry?

What does your partner do when angry?

10. What strengths do you have that support resolving differences?

What strengths does your partner have?

11. Do you spend time alone?

Do you enjoy your free time?

Does planning how to spend it create anxiety for you?

12. Do you have separate friendships with people who are not mutual friends?

Does this create conflict in your relationship?

13. Are you comfortable doing activities away from your partner?

What do you like to do?

How comfortable are you with your partner spending time away from you?

14. On a scale of 1 to 10, how open are you in expressing your innermost wants, thoughts, desires, and feelings to your partner? (1 is totally closed, and 10 is totally open). _____

15. When you feel like you want support or encouragement from your partner, do you get it?

How?

When your partner wants support or encouragement from you, do you feel that you give it?

How?

16. Do you support your partner's development as an individual?

How (give an example)?

17. Describe your sexual relationship.

What do you find most satisfying about it?

What do you find least satisfying about it?

How has your sexual relationship changed since you were first together?

18. What is one thing that you wish was different about your sexual relationship?

19. When do you feel most gratified in your relationship?

20. Do the two of you have joint commitments to goals, projects, works, or social causes?

Does this add or detract from the bond between you?

21. If your relationship was a movie, drama, or book, what would it be titled?

How would it end?

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Partner #2 Name:_____ DOB: _____

PHQ-9 Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Circle number to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
10. Little interest or pleasure in doing things…	0	1	2	3
11. Feeling down, depressed, or hopeless…	0	1	2	3
12. Trouble falling or staying asleep, or sleeping too much……	0	1	2	3
13. Feeling tired or having little energy…..	0	1	2	3
14. Poor appetite or eating……	0	1	2	3
15. Feeling bad about yourself – or that you are a failure or have let yourself or your family down……	0	1	2	3
16. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
17. 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
18. Thoughts that you would be better off dead or of hurting yourself in some way…	0	1	2	3

Columns Totals ____ + ____ + ____ + ____

= Total Score _____

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Partner #2 Name:_____ DOB: _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
(Circle number to indicate your answer)				
8. Feeling nervous, anxious or on the edge	0	1	2	3
9. Not being able to stop or control worrying	0	1	2	3
10. Worrying too much about different things	0	1	2	3
11. Trouble relaxing	0	1	2	3
12. Being so restless that it is hard to sit still	0	1	2	3
13. Becoming easily annoyed or irritable	0	1	2	3
14. Feeling afraid as if something awful might happen	0	1	2	3
Column totals:	+	+	+	
	___	____	____	____

= Total Score _____

If you circled 1 -3 on any items above, 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**
□	□	□	□

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Partner #3 Name:_____ DOB: _____

CAGE-AID QUESTIONNAIRE

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Please circle your answer.

Questions:

5. Have you ever felt that you ought to cut down on your drinking or drug use?
   YES NO

6. Have people annoyed you by criticizing your drinking or drug use?

   YES NO

7. Have you ever felt bad or guilty about your drinking or drug use?

   YES NO

8. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

   YES NO

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PARTNER QUESTIONNAIRE

Name Partner #2:_____

Date:_____

Directions: Each partner needs to fill out this questionnaire separately.

1. What is the problem that led you to decide to come to therapy?
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
2. How long have you and your partner been together?_____
3. In what form (i.e., dating, living together, married)? _____
4. How was the decision to live together or marry made?
   _____
   _____
   _____
   _____
   _____
   _____
   _____

5. What was the very beginning of your relationship like?

How long did this phase last?

6. What was your first disillusionment?

What happened and how did you resolve it?

Did this lead to any changes in your relationship?

7. When did you first become aware of significant differences between the two of you?

How are the two of you similar?

How are you different?

8. What do you do when there is conflict between the two of you?

What does your partner do?

9. What do you do when you are angry?

What does your partner do when angry?

10. What strengths do you have that support resolving differences?

What strengths does your partner have?

11. Do you spend time alone?

Do you enjoy your free time?

Does planning how to spend it create anxiety for you?

12. Do you have separate friendships with people who are not mutual friends?

Does this create conflict in your relationship?

13. Are you comfortable doing activities away from your partner?

What do you like to do?

How comfortable are you with your partner spending time away from you?

14. On a scale of 1 to 10, how open are you in expressing your innermost wants, thoughts, desires, and feelings to your partner? (1 is totally closed, and 10 is totally open). _____

15. When you feel like you want to support or encouragement from your partner, do you get it?

    How?

    When your partner wants support or encouragement from you, do you feel that you give it?

    How?

16. Do you support your partner's development as an individual?

    How (give an example)?

17. Describe your sexual relationship.

What do you find most satisfying about it?

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How has your sexual relationship changed since you were first together?

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