OVER THE RAINBOW PSYCHOTHERAPY, PLLC
Cynthia Denise Porter, LPC-S
Revised 11-15-15

DATE ________________ **NAME** ______________________________________ **DOB** ________________

FORMS RECEIVED

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.
2. I have received the "Financial Policies Notice (revised 11-15-15)."
3. I have received the "Confidentiality Notice (revised 11-15-15)"
4. I have received the "Emergency Procedures Information /Appointment Protocol Notice (revised 11-15-15)."
5. I have received the "Treatment Process and Termination Information Notice (revised 11-15-15)"
6. I have received the notice entitled, "Client Rights Notice (revised 11-15-15)".
7. I have received the "Notice of Privacy Practices (revised 11-15-15)."
8. I have received the notice entitled, "What to Expect from Your Licensed Professional Counselor"
9. I have received a notice entitled "EMDR" which explains the treatment I will receive (if applicable).

REGARDING SAFETY

My safety is of the utmost concern and, therefore, I give my permission to notify those close to me
who can help keep me safe in the event that it is determined that I have become a danger to myself or others.
I hereby give my permission in advance to inform the following individuals:

____________________________ ____________ ____________________
Full Name Relationship Phone #

____________________________ ____________ ____________________
Full Name Relationship Phone #

ACKNOWLEDGEMENTS

I, authorize, Cynthia Denise Porter, LPC- S/Over the Rainbow Psychotherapy, PLLC to provide mental health services.

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.

________________________________ ________________________________ ______________
Patient/Guardian Name Patient /Guardian Signature Date

HEALTHCARE PROVIDERS RELEASE FORM

INSTRUCTIONS:

> **Communication and collaboration among your healthcare providers is essential for the delivery of integrated quality care. If fact, many managed care companies require that we have interaction with your primary care physician and your psychiatrist. 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.**

I_____________________________________(DOB _____________), authorize Cynthia Denise Porter, LPC-S/Over the Rainbow Psychotherapy, PLLC to disclose to and receive information from my primary care physician, Dr. ________________________________ whose practice is in (city) _________________ and from my psychiatrist, Dr. ___________________ whose practice is in (city) ________________ 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

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Credit Card Preauthorization

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 **$150.00** 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 remains 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 ______________

Name ______________________________ Date ______________

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 __________

Name ______________________________ Date ______________

GAD-7 Anxiety

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 _____

CAGE-AID QUESTIONNAIRE

Patient Name:____________________________ Date of Visit:_______________

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