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Licensed Psychologist
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Peachtree Corners, GA 30092
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Informed Consent for Psychological Testing-Adult

Welcome to my practice! Thank you for contacting me for the opportunity to help. I look forward to working with you and your child with the goals of understanding his or her abilities, including both the strengths and any areas of difficulty, and making recommendations that may include a range of interventions that can support the way your child learns and improve their experience in school and their confidence in everyday life. Although this document is long and sometimes complicated, please read it carefully in its entirety and ask any questions you have about the content. When you sign this document, it will represent an agreement between us.

CREDENTIALS:
I am a Licensed Psychologist in Georgia. I hold a doctoral degree from the University of South Carolina in School Psychology with an additional year in the Clinical Psychology program for supervision in adult Psychodynamic Psychotherapy, Marital, and Sex therapy.

PRACTICE STRUCTURE:
I am in independent practice and am not affiliated with any other individual or practice.

WHAT IS PSYCHOLOGICAL TESTING?
Psychological evaluation is a process that includes a combination of clinical interview, completion of written questionnaires, and use of a variety of standardized measures in two or more one-on-one appointments with you or your child or adolescent. Depending upon the individual concerns and questions to be answered by the evaluation, testing may include measures of:

- Cognitive Ability
- Academic Achievement and Learning Progress
- Attention and Executive Functioning
- Visual and Auditory Information Processing
- Problem Solving Strategies
- Motor and Visual Perceptual Abilities
- Memory
- Behavioral and Emotional Functioning

WHAT IS THE PROCESS?
The first appointment is an initial evaluation, which typically includes a discussion with the client. For children or adolescents, the parents are interviewed to learn more about the current concerns and difficulties, as well as to gather background history and information about school functioning and, to review the findings from written questionnaires completed in advance. Information from this meeting helps with the final selection of measures for the test battery. At this first meeting, you may be asked to provide additional records, such as report cards and prior testing reports and, for your written authorization to provide permission to communicate with other professionals involved in your child's care.

The testing sessions are usually scheduled in two or three sessions on separate days, typically in the morning, lasting 3-1/2 – 4 hours each. The specific measures chosen depend on the concerns to be addressed.

The family feedback meeting is scheduled 2 – 4 weeks after the final testing session -- and after all other supporting data and reports have been received -- to review the test results and recommendations. At that appointment, you will be provided with a comprehensive written report.

USE OF THE EVALUATION REPORT:

After the written report has been prepared and shared, the usual next step is to share the report with other involved professionals including but not limited to the school team, the pediatrician and other medical professionals. On many occasions, parents set up a meeting at the school to go over the recommendations and determine if additional supports can be put in place.

Please be aware that it is not in my control whether the school will agree to implement the recommendations. The recommendations will be practical, driven by the test data and relevant to the needs of your child in the context of the evaluation results.

While I stay up to date on the rules for provision of accommodations for standardized testing and the types of test instruments recommended for consideration for accommodations, I do not have any special power to obtain approval for accommodations for standardized testing such as the ACT, SAT or AP tests. I want you to know in advance that I will not change the presentation of the results, the diagnoses or the recommendations purely so that they meet criteria for special supports or accommodations; to do so would be unethical.

The standardized testing companies continue to be particularly conservative in granting accommodations to students who do not have a long standing history of receiving and using those very accommodations in their school setting. If the College Board or ACT denies the student accommodations, you may ask me to write a Letter of Appeal on the behalf of the student.

Typically, these letters must be completed in a short period of time and require a substantive review of the report and the denial. This type of letter takes additional time and will require a separate fee, which can be discussed if or when these circumstances occur for your child.

FEES AND PAYMENT:

A complete psychological evaluation involves the initial appointment, preceded by scoring and interpretation of written questionnaire measures sent in advance of the first appointment, followed by face-to-face testing measures with the examiner, usually over two to three appointments and taking seven to eight hours total. Testing also involves scoring and interpretation of the results and the preparation of an integrative written report. The writing of the report usually takes at least as many hours as and often even more hours to complete than the testing time itself.

The fee for the comprehensive psychological evaluation is generally $2500.00. This includes the testing sessions, the family feedback meeting and the preparation of the comprehensive written report. The testing evaluation fee is due at the first testing session. The full fee is due when the testing is complete and before the scheduled feedback meeting.

INSURANCE INFORMATION:

If I am an out-of-network provider, this means that I am not a member of a provider network for your managed care plan. Your insurance plan may or *may not* cover visits to an out-of-network provider. Some insurance companies reimburse at different amounts depending on whether you see a provider with whom they have a contract, called an "in-network" provider.

You are responsible for payment of all charges, submission of bills to your insurance company, obtaining information about your coverage and making certain that we are both aware of any authorization requirements for psychological testing. I will provide you with detailed receipts including all the necessary information should you choose to submit to your insurance company for reimbursement. Many insurance plans cover psychological services and many require the *member* to make a telephone call before an initial appointment. If you are interested in submitting for reimbursement, I recommend that you contact your insurance company to request information about out-of-network benefits for psychological consultation and testing prior to the first appointment.

If you call your insurance company, let them know that you are calling for "preauthorization for psychological testing." They may ask you for CPT Codes. These are listed below.

90791 Initial Diagnostic Interview
96101 Psychological Testing
90847 Family Feedback Meeting

I suggest that you obtain any special forms and a fax number for paperwork that they tell you is required. If your insurance company authorizes the testing, they will use the date they *receive* the forms for the start date of the authorization. I am not in control of how quickly they will process this request or whether they will authorize testing at all. I will fill out forms if you provide them for me and will give you a copy of forms that I submit so that you can follow up with them directly.

CANCELLATION POLICY:

If you must cancel an appointment, please give a *minimum* of *48 hours advance notice.* If this minimum is not provided, you will be charged a cancellation fee of $50 for the initial appointment or family feedback meeting and a $200 fee for the cancellation of a testing appointment. Given the large amount of reserved time made available to you for testing appointments, short notice cancellations for the testing sessions may result in the cancellation of subsequent appointments.

CONFIDENTIALITY:

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information to others with your (the patient or the parent for children and adolescent) written permission. There are a few exceptions that have rarely or never occurred in my practice but about which you should be informed:

- In proceedings involving custody or those in which your child's emotional condition is an issue, a judge may determine that my testimony will be ordered. If you choose to include your child's mental or emotional status as part of a court proceeding, doing so waives your privilege of confidentiality.

- If a patient or patient's parent or guardian files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If I have reason to believe that a child has been subjected to abuse or neglect, the law requires that I file a report with the appropriate government agency.
- If you submit your bill to your insurance company for reimbursement, they require that I provide a clinical diagnosis and may also request clinical information. If your company requires forms to be completed to request authorization for psychological testing, these forms may include clinical information and diagnoses that are faxed to the company for review or discussed in a telephone call with a reviewer employed by the company.
- If you are divorced, both parents have equal ability to obtain information from mental health records and both parents *must* give permission for the provision of psychological services.

If a situation like one of those described above occurs, I will make every effort to fully discuss it with you before taking any action. Otherwise, I will not tell *anyone anything* about you or your child's evaluation or even that you are a patient, without your knowledge and written consent.

CONTACTING ME:

The best way to reach me is through the confidential voice mail answering system. Please be aware that I do not answer calls when I am in appointments, but I check voice mail often. I will make every effort to return your call within 24 – 48 hours, except for weekends and holidays, but cannot guarantee that this is always possible. If you are not able to reach me and feel that your child is having an acute mental health emergency and you cannot wait for a return call, please contact your child's medical provider or go to the nearest emergency room.

SPECIAL CIRCUMSTANCES:

I provide consultation, psychological evaluation, and psychotherapy services to assist with problem resolution and do not do specialized evaluations to be used in legal proceedings, such as for forensic issues or court proceedings for custody determination. If you anticipate that this is needed, I will refer you to professionals who have this area of specialization in their practice.

Although very unlikely, it is important that I share the following information in advance: In the event that I am required by subpoena or court order to testify in any matter related to the psychological evaluation services, you will be expected to pay for all of the professional time used, including preparation and transportation costs, even if I am called to testify by another party. If I am subpoenaed by another party in litigation with you and you do not wish the subpoena answered, it is your responsibility to contract with your lawyer to quash the subpoena or to sign a waiver of confidentiality.

Because of the substantial difficulty of managing such legal involvement while maintaining scheduled appointments in my practice at the same time, the fees are $250 per hour for preparation and attendance at any legal proceeding.

Your signature below indicates that you have read the information in this agreement and agree to abide by its terms during our professional relationship. By your signature below, you indicate that:

- You have been informed of and understand the type of services to be provided.
- You have been informed of the limits of confidentiality.
- You understand and agree to the payment and cancellation policies.
- You accept full responsibility for all fees incurred in completing the psychological evaluation as spelled out in the agreement.
- You understand that, if you are provided with a digital copy of the report, you are not permitted to make any changes to the report.

Name of Patient: _____

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Printed name serves as an electronic signature if you cannot sign Relationship to Patient

_____ _____
Signature of Second Parent/Guardian Date

_____ _____
Printed name serves as an electronic signature if you cannot sign Relationship to Patient

CLIENT INFORMATION TESTING FORM

Today's Date:					
Presenting Problem:					
CLIENT'S INFORMATION					
Client's Name:			**SPOUSE OR PARTNER'S INFORMATION**		
Date of Birth:		**Age:**	**Spouse's or Partner's Name:**		
Address:			**Date of Brith / Age**	/	
City/State/Zip:			**Education:**		
Cell Phone:			**Employer:**		
Email Address:			**Cell Phone:**		
Employer/ Occupation:			**Office Phone:**		
Education:			**E-Mail:**		
Emergency Contact & Cell:			**Physician's Name:**		
Physician's Name & Cell:			**Physician's Phone Number:**		
Marital Status:			**Childrens's Names and Ages:**		

INSURED'S INFORMATION IF USING INSURANCE			
Primary Insurance Company:		**Secondary Insurance Company:**	
Insured's Name:		**Insured's Name:**	
Insured's Employer:		**Insured's Employer:**	
Insured's Date of Birth:		**Insured's Date of Birth:**	
Address:		**Address:**	
State/Zip Code:		**State/Zip Code:**	
Ins. Co. Tel. #:		**Ins. Co. Tel. #:**	
Employer:		**Employer:**	
Policy Number:		**Policy Number:**	
Group Number:		**Group Number:**	
Effective Date:		**Effective Date:**	
Deductible:		**Deductible:**	
Amount Met:		**Amount Met:**	
# of Sess. Per Cal. Yr.:		**# of Sess. Per Cal. Yr.:**	
Co-Pay:		**Co-Pay:**	
Precert? Auth. #:		**Initial Diagnostic Impression:**	

CREDIT CARD AND AUTHORIZATION FORM

Credit Card Holder:	
Credit Card Number:	
Zip Code:	
Expirations Date:	***Security Code:***

Authorizing Signature
Your typed name will represent your signature if you cannot sign.

Date

The services rendered are checked below.

( ) Diagnostic Interview
( ) Psychotherapy 50-60 Min.
( ) Psychological Evaluation
( ) Court Testimony
( ) Two-Day Couples Retreat
( ) Written Correspondence
( ) Test Results Feedback
( ) School Board, IEP or Tribunal Hearing
( ) Phone Consultations greater than 10 minutes

OFFICE POLICIES, PRIVACY NOTICE AND FINANCIAL AGREEMENT FOR PSYCHOLOGICAL SERVICES

Welcome to my practice. This document contains important information about my professional services and business policies. HIPAA, the Healthcare Portability Act, which I will explain elsewhere, provides you with additional rights. The law requires that I obtain your signature acknowledging that I have provided you with this information at or before the end of the first meeting. Although these documents are long and sometimes complex, it is very important that you read them carefully. I can discuss any questions you have about the procedures during the first meeting. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Although I may share office space with other therapists at 4046 Wetherburn Way, Suite 7, Peachtree Corners, GA 30092, we are each independent practitioners and not responsible or liable for one another's practices or procedures. This document consists of my office policies, your rights to confidentiality and records under the law, your permission to treat you and/or your child(ren) and our financial agreement.

PSYCHOLOGICAL SERVICES

I specialize in the assessment, diagnosis and treatment of learning, relationship, psychological, and some neuropsychological disorders. By signing this agreement, you are giving consent for yourself or your child/adolescent to undergo psychological evaluation and/or treatment. As a licensed psychologist, I will be performing this evaluation and/or treatment.

Psychological Testing

A psychological evaluation is a comprehensive assessment of cognitive, educational, and social/emotional functioning. Over a period of 4 to 8 hours, standard testing procedures assess various abilities that relate to cognition, learning, memory, problem solving and critical thinking. The evaluation also measures psychological dimensions relating to social and emotional functioning. The evaluation may also be used to procure public school or college classroom/teaching accommodations for you or your child in order to obtain more effective learning experiences. Also, psychological testing may be used to provide medical clearance, diagnosis of a mental illness, fitness for duty to return to work, or parental competence in a court of law. If you have further questions about the purpose and potential benefits of a psychological evaluation, I will be happy to provide additional information.

Psychotherapy

Psychotherapy, or mental health counseling, is a complex array of many activities that serve to build a trusting relationship between the client and their therapist, insight into one's emotional and/or behavioral problems, and "processing" or making sense of troubling, confusing, and traumatic events in one's past. This array of activities

may consist of play, dance or movement, physical exercise, education, learning, application and practice of that learning, assimilation of learning into behavior and integration of what is learned and practiced into ethical, morally mature, socially responsible and healthy personality functioning. The transformation that occurs through this complex array of activities with the therapist involves easing of personal defense mechanisms that permit insight into one's own emotional life and habitual ways of behaving socially.

Self-control and improved social and moral functioning comes through the development of self-awareness, rational thought, appropriate expression of emotions, planning, anticipation of consequences, mental flexibility, self-acceptance, genuine regard for others' feelings, beliefs, and opinions, and capitalizing on one's existing strengths and resources.

By forming a therapeutic alliance with Dr. Kovner the client works to improve their chances of success in achieving the goals of emotional stability, personal and interpersonal growth, occupational and educational satisfaction and social responsibility.

Furthermore, research has shown that improvement in mental health can have a beneficial affect on physical health.

Consultation and Court Room Testimony

Dr. Kovner provides consultation to teachers, school personnel, lawyers and other professional, as well as testifying in court.

CONTACT INFORMATION AND EMERGENCY PROCEDURES

Often I am not available immediately by telephone. I do not answer the phone when I am in a meeting with a client. On days that I are not in the office, I check voice mail frequently. When I am unavailable, the telephone is answered by the office manager or an answering machine. I will try to return your call within one business day of receiving it, with the exception of holidays and vacations.

If you are difficult to reach, please inform us of some times when you will be available. My practice does not have 24 hour crisis availability, support staff, or a psychiatrist. If it is possible you will need crisis services over the course of treatment it is important that you discuss this point with me as soon as possible. I may recommend that you seek services with a provider who can offer more crisis coverage than can be provided by my private practice.

However, in case of an emergency, this is the protocol I follow. In an emergency, you may try to reach me at the office number. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. In a situation where serious harm may occur, call 911 or get safe transportation to the nearest hospital emergency room. If you are able to wait for a return call, clients with life-threatening emergencies will be seen immediately, or directed to emergency care. Clients with non-life threatening emergency needs will be seen within (6) hours or directed to emergency care. Clients with urgent care needs will receive care within 24 hours.

If I will be unavailable for an extended time and you provide me with a written request I will provide you with the name of a colleague to contact.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in a Clinical Record. Except in unusual circumstances where that disclosure would physically or emotionally endanger you and/or others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. In most circumstances, I am allowed to charge a copying fee of $0.10 per page (and charge for certain other expenses such as postage and envelopes).

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

You also may add information to your records when I review them with you if you believe they contain inaccurate or incomplete information.

It is my office policy to retain clients' records for seven years after the end of our therapy.

Please note that in some cases our files may include information from other treatment providers that clients have given me written permission to obtain. If you have given me permission to obtain such records, I cannot provide them to you if you ask to review your files. Instead, I would ask for you to contact the provider who created the records and obtain copies directly from her or him.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. The written notice of these HIPAA rights are framed on the wall of the waiting room and a copy can by provided to you if you request it. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. I am happy to discuss any of these rights with you. For a detailed description of your rights under HIPAA, go to the Health and Human Services web page below.

https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about you or your child's treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Georgia law. However, in the following situations, no authorization is required: Disclosures required by health insurers or to collect overdue fees; if you are involved in a court proceeding and a judge waives your privilege to confidentiality. Generally, I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a government agency is requesting the information for health oversight activities, I may be required to provide it for

them. In the case of suspected child abuse, the privilege is waived because all psychologists are mandated court reporters of child abuse.

Additionally, I would not need authorization to disclose your records under the following circumstances:

1. If a you file a complaint or lawsuit against me, I may disclose relevant information regarding you and your treatment in order to defend myself.

2. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of a client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.

3. You should be aware that I practice with other mental health professionals and that I occasionally employ administrative staff. In some cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations in which we are legally obligated to take actions where your confidentiality privileges are waived. These situations include instances where we believe it is necessary to attempt to protect others from harm. Under such circumstances, I may have to reveal some information about a patient's treatment. These situations are unusual in our practice, and include:

4. If I know or have reasonable cause to suspect that a child under 18 has been or is likely to be abused or neglected or that a disabled person has been abused, neglected or exploited, the law requires that I file a report with the appropriate government agency, usually the Georgia Department of Child Protective Services. Once such a report is filed, I may be required to provide additional information.

5. If I determine that the patient poses a direct threat of imminent harm to the health or safety of any individual, including himself/herself, I may be required to disclose information in order to take protective action(s). These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can assist in providing protection.

6. If you have filed a worker's compensation claim and I are being compensated for your treatment by your employer or its insurance company as a result of that claim, I must provide, upon appropriate request, legally required reports and other information related to your condition.

INSURANCE & CONFIDENTIALITY

You should be aware that most insurance companies require you to authorize your treating psychologist to provide

them with a clinical diagnosis and, sometimes, detailed clinical records. In that case, we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information data bank. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit our disclosure to what is necessary.

GENERAL OFFICE POLICIES & HOUSEKEEPING

Fire Arms and Other Weapons

This building is a "Weapons-Free" zone. With respect to our clients who may have adverse reactions to weaponry, please leave yours locked up in your vehicle.

Recording of Sessions

Recording of therapy sessions is prohibited unless you and Dr. Kovner have agreed to use recordings for a thepeutic reasons. In that case a separate signed agreement will be obtained and all recordings will be destroyed after their use in therapy.

Eating or Smoking

No Eating or Smoking is permitted in the Building. If you smoke outside, please throw your used cigarette into the receptacle on the porch. Children are to wait quietly in the waiting room. Parents must accompany young children to the bathroom and make sure all doors are closed and the facilities are left clean. Do not leave children unsupervised in or outside of the office.

Restroom

Parents must accompany young children to the bathroom and make sure all doors are closed and the facilities are left clean. Do not flush diapers or leave soiled diapers on the premises.

The Waiting Area

- Clients are to wait quietly in the waiting room.
- Please be courteous and turn your cell phones to vibrate.
- Please use ear buds to listen to music and keep voices down to a whisper if you talk on your cell phone or step outside.
- We use the radio to provide the Office Manager with privacy. She has limited time. Please respect her time and privacy. All clinical information is to be presented ***in therapy sessions by appointment***.

FINANCIAL AGREEMENT

Dr. Kovner's usual and customary fee is $200.00 per hour. He charges this amount for other professional services you may need. Other services include:

- Psychological Testing
- Report Writing
- Telephone consultations lasting longer than 10 minutes
- Consultations with other professionals
- Preparing records or treatment summaries for court

If you become involved in legal proceedings through the court system or hire me to support your child in an IEP meeting, Board Meeting, or Tribunal Hearing through the school system, you will be charged $200.00 per hour for travel, wait time, preparation and attendance. I require a $1,600.00 retainer before work is begun.

If you plan to use your health care insurance, you are expected to contact them and be informed of your Mental Health benefits. We cannot be responsible for interpreting your insurance benefits. Unless your insurance company has contracted directly with the Kovner Center, this office cannot call, contact or negotiate for you with your insurance company. However, we will print out statements for you to submit for reimbursement. Any special arrangements must be discussed in advanced with the office manager. Missed appointments are generally not insurance reimbursable.

RETURNED CHECK FEES

There will be a $35.00 charge for each returned check to cover all of the expenses involved in paying bank fees and other resulting insufficient funds charges.

LATE FEES AND NON-PAYMENT ACTIONS

Customer agrees to be responsible for all costs of collection on unpaid balances including, but not limited to, 1 ½% interest (18% annually), collection fees (up to 50%), court costs and reasonable attorney fees.

CANCELLATION POLICY AND RESCHEDULING APPOINTMENTS

In order to accommodate you we offer flexible appointment hours, including after-school and evening hours. When you schedule an appointment, that time is yours and you pay for that time whether you use it and attend your appointment or you fail to show up or fail to cancel your appointment ***at least two days prior. We charge a $50.00 fee for not canceling your appointment 2 days (48 hours) in advance.*** We refer to this as the ***Cancellation Fee***. The fee may be waived at Dr. Kovner's discretion when you were unable to attend due to circumstances beyond your control.

Individuals who miss two consecutive appointments without advanced notification will be taken off the calendar. There may be situations when I agree that you were unable to attend due to circumstances beyond your control. Under these circumstances, the fee will be waived at Dr. Kovner's discretion and you will be able to schedule your next appointment.

INTENT TO USE MEDICAL INSURANCE

Please indicate below your intention to use health insurance.

☐ I do not have mental health insurance.

☐ I have decided not to utilize my health insurance to cover the cost of these services.

☐ I have decided to use my health insurance to cover the cost of these services. My signature on this agreement verifies that I understand that a pre-authorization from my insurance company is not a guarantee that your insurance company will pay for these services and that if your insurance company chooses not to pay, or to pay only partially for this service, you agree to pay the balance on your account in full.

Please check your coverage carefully prior to your first session. You can call the number on your insurance card and ask the following questions:

1. Do I have benefits for outpatient mental health services?
2. Do I have coverage when I see an Out of Network provider?
3. Will my insurance offer a "single case agreement" to allow payment for an Out of Network provider?
4. What is the maximum dollar amount or number of sessions per year covered by and what dates does it start over?
5. How much is my deductible and has it been met this year?
6. Is there a separate deductible for mental health services?
7. What is my co-pay for mental health services?
8. What are the "allowable amounts" for procedure codes 90791 (diagnostic evaluation), 90834 (psychotherapy, 45 minute), and 90837 (psychotherapy, 60 minute)?

If you have medical insurance that covers outpatient psychotherapy, you will only need to pay the portion of your fee not covered by insurance. Insurance claims will be submitted for you. If I, or your insurance company, determine that your psychotherapy is not "medically necessary" according to the guidelines of the insurance industry, you will be responsible for the fee, as insurance covers only such "medically necessary" services. If your insurance company has not paid your account in full within 90 days, the balance will be billed to you or transferred to your credit card.

ACKNOWLEDGMENT OF REVIEW OF OUR OFFICE, FINANCIAL AND CANCELLATION POLICIES & AGREEMENTS, AND PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with, understand and accept the policies in the "HIPAA Notice of Privacy Practices" as well as Dr. Kovner's "Office Policies, Cancellation Requirements" and Financial Obligations. Therefore, I have been advised of how health information about me may be used and disclosed by Dr. Kovner, how I may obtain access to and control this information and my responsibilities to pay all fees not covered by insurance and the costs associated with late fees and collection services.

*X*_____ _____

Signature of Patient or Personal Representative (Type Your Name if You Cannot SIgn) *DATE*

1. Please list who you want to have access to your pertinent medical information? (i.e.: family member, spouse, significant other):

Name	*Relationship to Client*	*Phone Number*
Name	*Relationship to Client*	*Phone Number*
Name	*Relationship to Client*	*Phone Number*

2. May we leave a message on your answering machine? YES ☐ *NO* ☐

3. Preferred method of contacting you:

*Home #*_____*Cell #*_____*Work #*_____

THIS SECTION WILL BE COMPLETED IF THE WRITTEN ACKNOWLEDGMENT IS NOT OBTAINED

We have made a good faith effort to obtain an individual's acknowledgment, but the acknowledgment was not obtained for the following reason(s):

☐ *The individual refuses to sign and/or did not return his or her receipt of the Acknowledgment.*

☐ ***Other:***

Date:

The Kovner Center For Behavioral Health & Psychological Testing

4046 Wetherburn Way, Suite 7
Peachtree Corners, Geogia 30092

Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

I. COMMITMENT TO YOUR PRIVACY: The Kovner Center is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that The Kovner Center maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, The Kovner Center is required to ensure that your PHI is kept private. This Notice explains when, why, and how The Kovner Center would use and/or disclose your PHI. Use of PHI means when The Kovner Center shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when The Kovner Center releases, transfers, gives, or otherwise reveals it to a third party outside of the The Kovner Center. With some exceptions, The Kovner Center may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, The Kovner Center is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by The Kovner Center. Please note that The Kovner Center reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that The Kovner Center has created or maintained in the past and for any of your records that The Kovner Center may create or maintain in the future. The Kovner Center will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of The Kovner Center's Notice of Privacy Practices.

IV. HOW The Kovner Center MAY USE AND DISCLOSE YOUR PHI: The Kovner Center will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: The Kovner Center may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, The Kovner Center may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, The Kovner Center will always ask for your authorization in writing prior to any such consultation.
2. For Health Care Operations: The Kovner Center may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
3. To Obtain Payment for Treatment: The Kovner Center may use and disclose your PHI to bill and collect payment for the treatment and services The Kovner Center provided to you. Example: The Kovner Center might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. The Kovner Center could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for The Kovner Center's office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, The Kovner Center will always do its best to reconcile this with you first prior to involving any outside agency.
4. Employees and Business Associates: There may be instances where services are provided to The Kovner Center by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, The Kovner Center will have a written contract that requires the

employee or business associate to maintain the same high standards of safeguarding your privacy that is required of The Kovner Center.

Note: This state and Federal law provides additional protection for certain types of health information, including alcohol or drug abuse, mental health and AIDS/HIV, and may limit whether and how The Kovner Center may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – The Kovner Center may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. Law Enforcement: Subject to certain conditions, The Kovner Center may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: The Kovner Center may make a disclosure to the appropriate officials when a law requires The Kovner Center to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. Lawsuits and Disputes: The Kovner Center may disclose information about you to respond to a court or administrative order or a search warrant. The Kovner Center may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. The Kovner Center will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.

3. Public Health Risks: The Kovner Center may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.

4. Food and Drug Administration (FDA): The Kovner Center may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

5. Serious Threat to Health or Safety: The Kovner Center may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if The Kovner Center determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, The Kovner Center may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.

6. Minors: If you are a minor (under 18 years of age), The Kovner Center may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.

7. Abuse and Neglect: The Kovner Center may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If The Kovner Center has a reasonable suspicion of child abuse or neglect, The Kovner Center will report this to the Georgia Department of Child and Family Services.

8. Coroners, Medical Examiners, and Funeral Directors: The Kovner Center may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. The Kovner Center may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.

9. Communications with Family, Friends, or Others: The Kovner Center may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, The Kovner Center may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

10. Military and Veterans: If you are a member of the armed forces, The Kovner Center may release PHI about you as required by military command authorities. The Kovner Center may also release PHI about foreign military personnel to the appropriate military authority.

11. National Security, Protective Services for the President, and Intelligence Activities: The Kovner Center may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.

12. Correctional Institutions: If you are or become an inmate of a correctional institution, The Kovner Center may

disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

13. For Research Purposes: In certain limited circumstances, The Kovner Center may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.

14. For Workers' Compensation Purposes: The Kovner Center may provide PHI in order to comply with Workers' Compensation or similar programs established by law.

15. Appointment Reminders: The Kovner Center is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.

16. Health Oversight Activities: The Kovner Center may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess The Kovner Center's compliance with HIPAA regulations.

17. If Disclosure is Otherwise Specifically Required by Law.

18. In the Following Cases, The Kovner Center Will Never Share Your Information Unless You Give us Written Permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, The Kovner Center will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying The Kovner Center in writing of your decision. You understand that The Kovner Center is unable to take back any disclosures it has already made with your permission, The Kovner Center will continue to comply with laws that require certain disclosures, and The Kovner Center is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in The Kovner Center's possession, or to get copies of it; however, you must request it in writing. If The Kovner Center does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from The Kovner Center within 30 days of receiving your written request. Under certain circumstances, The Kovner Center may feel it must deny your request, but if it does, The Kovner Center will give you, in writing, the reasons for the denial. The Kovner Center will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. The Kovner Center may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that The Kovner Center limit how it uses and discloses your PHI. While The Kovner Center will consider your request, it is not legally bound to agree. If The Kovner Center does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You do not have the right to limit the uses and disclosures that The Kovner Center is legally required or permitted to make.

3. The Right to Choose How The Kovner Center Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). The Kovner Center is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that The Kovner Center has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include

disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6year period and starting after April 14, 2003.

The Kovner Center will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. The Kovner Center will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Choose Someone to Act for You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that The Kovner Center correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of The Kovner Center's receipt of your request. Management Institute may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than The Kovner Center. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and The Kovner Center's denial will be attached to any future disclosures of your PHI. If The Kovner Center approves your request, it will make the change(s) to your PHI. Additionally, The Kovner Center will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

7. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

8. Submit all Written Requests: Submit to The Kovner Center's Director and Privacy Officer, _____, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision The Kovner Center madeabout access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. The Kovner Center will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint. Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. The Kovner Center's Responsibilities: We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Date of Last Revision: 08/12/18

SK Symptoms Checklist: Adult Form

By Steven Kovner, Ph.D.

Name: _____ Age:_____ Gender:_____ Date:_____

ADHD

- ☐ Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
- ☐ Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
- ☐ Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
- ☐ Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
- ☐ Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
- ☐ Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
- ☐ Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
- ☐ Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
- ☐ Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

HY/Imp

- ☐ Often fidgets with or taps hands or feet or squirms in seat.
- ☐ Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
- ☐ Often runs about or climbs in situations where it is inappropriate.
- ☐ Often unable to play or engage in leisure activities quietly.
- ☐ Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- ☐ Often talks excessively.
- ☐ Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
- ☐ Often has difficulty waiting his or her turn (e.g., while waiting in line).

- [ ] Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).
- [ ] Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
- [ ] Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
- [ ] There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
- [ ] The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

D

- [ ] Persistent, sad, anxious or "empty" feelings
- [ ] Feelings of hopelessness and/or pessimism
- [ ] Feelings of guilt, worthlessness and/or helplessness
- [ ] Irritability, restlessness
- [ ] Loss of interest in activities or hobbies once pleasurable, including sex
- [ ] Fatigue and decreased energy
- [ ] Difficulty concentrating, remembering details and making decisions
- [ ] Insomnia, early-morning wakefulness, or excessive sleeping
- [ ] Overeating, or appetite loss
- [ ] Thoughts of suicide, suicide attempts
- [ ] Persistent aches or pains, headaches, cramps or digestive problems that do not ease even with treatment

GAD

- [ ] Worry very much about everyday things for at least six months, even if there is little or no reason to worry about them
- [ ] Can't control the constant worries
- [ ] Worry much more than I should
- [ ] Can't relax.
- [ ] Have a hard time concentrating
- [ ] Am easily startled
- [ ] Have trouble falling asleep or staying asleep.
- [ ] Feeling tired for no reason
- [ ] Headaches
- [ ] Muscle tension and aches
- [ ] Having a hard time swallowing
- [ ] Trembling or twitching
- [ ] Being irritable
- [ ] Sweating
- [ ] Nausea
- [ ] Feeling lightheaded

- [ ] Feeling out of breath
- [ ] Having to go to the bathroom a lot
- [ ] Hot flashes.

PA

- [ ] Rapid heart rate
- [ ] Sweating
- [ ] Trembling
- [ ] Shortness of breath
- [ ] Hyperventilation
- [ ] Chills
- [ ] Hot flashes
- [ ] Nausea
- [ ] Abdorninal cramping
- [ ] Chest pain
- [ ] Headache
- [ ] Dizziness
- [ ] Faintness
- [ ] Tightness in your throat
- [ ] Trouble swallowing
- [ ] A sense of impending death

PTSD

- [ ] Bad dreams
- [ ] Flashbacks, or feeling like the scary event is happening again
- [ ] Scary thoughts you can't control
- [ ] Staying away from places and things that remind you of what happened
- [ ] Feeling worried, guilty, or sad
- [ ] Thoughts of hurting yourself or others

Ph

- [ ] Fear of places or situations where getting help or escape might be difficult., such as in a crowd or on a bridge?
- [ ] Persistent and unreasonable fear of an object or situation, such as flying, heights, animals, blood, etc.?
- [ ] Being unable to travel alone?
- [ ] Very anxious about being with other people
- [ ] Very self-conscious in front of other people
- [ ] Very worried about how they themselves will act
- [ ] Very afraid of being embarrassed in front of other people
- [ ] Very afraid that other people will judge you
- [ ] Worries for days or weeks before an event where other people will be
- [ ] Stays away from places where there are other people
- [ ] Has a hard time making friends and keeping friends

May have body symptoms when they are with other people, such as:

- [ ] Blushing
- [ ] Heavy sweating
- [ ] Trembling
- [ ] Nausea
- [ ] Has a hard time talking

OCD

- [ ] Has unwanted thoughts, ideas, images, or impulses that seem silly, nasty, or horrible
- [ ] Worries excessively about dirt, germs, or chemicals
- [ ] Constantly worries that something bad will happen because you may not have locked the door or turned off appliances
- [ ] Afraid you will act or speak aggressively when you really don't want to
- [ ] Must do things excessively or must repeat thoughts to feel comfortable
- [ ] Washes self or items excessively
- [ ] Check things over and over again or repeat things many times to be sure they are done properly
- [ ] Avoids situations or people you worry about hurting through aggressive words or deeds
- [ ] Keeps many useless things because you feel you can't throw them away

ASD As an infant:

- [ ] Did not babble, point, or make meaningful gestures by 1 year of age
- [ ] Did not speak one word by 16 months
- [ ] Did not combine two words by 2 years
- [ ] Did not respond to name
- [ ] Loses language or social skills
- [ ] Poor eye contact
- [ ] Did not seem to know how to play with toys
- [ ] Excessively lines up toys or other objects
- [ ] Is attached to one particular toy or object
- [ ] Did not smile
- [ ] At times seems to be hearing impaired
- [ ] Communication Difficulties
- [ ] Repetitive Behaviors
- [ ] Sensory problems
- [ ] Seizures

ED

- [ ] Emaciation
- [ ] A relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight
- [ ] A distortion of body image and intense fear of gaining weight
- [ ] A lack of menstruation among girls and women
- [ ] Extremely disturbed eating behavior

- [ ] Loses weight by dieting and exercising excessively
- [ ] Loses weight by self-induced vomiting, or misusing laxatives, diuretics or enemas
- [ ] See self as overweight
- [ ] Recurrent and frequent episodes of eating unusually large amounts of food
- [ ] Feeling a lack of control over the eating
- [ ] Fasting
- [ ] Overweight or obese
- [ ] Experience guilt, shame and/or distress about the binge-eating

Sz

- [ ] I see, hear, smell, or feel things that no one else can see, hear, or smell
- [ ] Invisible fingers touch my body when no one is near
- [ ] I can smell odors that no one else detects
- [ ] I see people or objects that others cannot see
- [ ] Neighbors can control my behavior with magnetic wave
- [ ] Trouble organizing thoughts or connecting them logically
- [ ] Thought blocking
- [ ] Agitated, repetitive or frozen in body movements
- [ ] Flat affect
- [ ] Talks in a dull or monotonous voice
- [ ] Lack of pleasure in everyday life
- [ ] Lack of ability to begin and sustain planned activities
- [ ] Speaking little, even when forced to interact
- [ ] Poor "executive functioning" (the ability to understand information and use it to make decisions
- [ ] Trouble focusing or paying attention
- [ ] Problems with "working memory" (the ability to use information immediately after learning

BiPD

- [ ] Feel very "up" or "high"
- [ ] Feel "jumpy" or "wired"
- [ ] Talk really fast about a lot of different things
- [ ] Agitated, irritable, or "touchy"
- [ ] Trouble relaxing or sleeping
- [ ] Think they can do a lot of things at once and are more active than usual
- [ ] Do risky things, like spend a lot of money or have reckless sex.
- [ ] Feel very "down" or sad
- [ ] Feel worried and empty
- [ ] Have trouble concentrating
- [ ] Forgets things a lot
- [ ] Lose interest in fun activities and become less active
- [ ] Feel tired or "slowed down"
- [ ] Have trouble sleeping
- [ ] Think about death or suicide.

BoPD

- ☐ Intense bouts of anger, depression and anxiety that may last only hours, or at most a day associated with episodes of impulsive aggression, self-injury, and drug or alcohol abuse
- ☐ Distortions in cognition and sense of self leading to frequent changes in long-term goals, career plans, jobs, friendships, gender identity, and values.
- ☐ Views self as fundamentally bad, or unworthy.
- ☐ Feels unfairly misunderstood or mistreated, bored, empty, and has little idea who they are.
- ☐ Feels isolated and lacking in social support, and may result in frantic efforts to avoid being alone.
- ☐ Often has highly unstable patterns of social relation
- ☐ Develops intense but stormy attachments
- ☐ Attitudes towards family, friends, and loved ones may suddenly shift from idealization (great admiration and love) to devaluation (intense anger and dislike)
- ☐ Fears of abandonment
- ☐ Excessive spending, binge eating and risky sex

ADDITIONAL QUESTIONNAIRES

ACE

Did a parent or other adult in the household often or very often swear at you, insult you, or put you down?

☐ **YES** ☐ **NO**

Did one of your parents often or very often push, grab, slap or throw something at you?

☐ **YES** ☐ **NO**

Did one of your parents often or very often hit you so hard that you had marks or were injured?

☐ **YES** ☐ **NO**

Did an adult or person at least 5 years older ever have you touch their body in a sexual way?

☐ **YES** ☐ **NO**

Did an adult or perosn at least 5 years older ever attempt oral, anal, or vaginal intercourse with you?

☐ **YES** ☐ **NO**

As a child, did you witness your mother sometimes, often , or very often pushed, grabbed, slapped, or had something thrown at her? ☐ **YES** ☐ **NO**

As a child, did you witness your mother sometimes, often , or very often kicked, bitten, hit with a fist, or hit with something hard? ☐ **YES** ☐ **NO**

SA

1.Have you used drugs other than those required for medical reasons? .....Y ☐ *N* ☐
2. Have you abused prescription drugs?.....Y ☐ *N* ☐
3. Do you abuse more than one drug at a time?.....Y ☐ *N* ☐
4. Can you get through the week without using drugs?.....Y ☐ *N* ☐
(other than those required for medical reasons)?.....Y ☐ *N* ☐
5.Are you always able to stop using drugs when you want to?.....Y ☐ *N* ☐

6. Do you abuse drugs on a continuous basis?.....Y ☐ N ☐
7.Do you try to limit your drug use to certain situations?.....Y ☐ N ☐
8.Have you had "blackouts" or "flashbacks" as a result of drug use?.....Y ☐ N ☐
9.Do you ever feel bad about your drug abuse?.....Y ☐ N ☐
10.Does your spouse (or parents) ever complain about your involvement with drugs?.....Y ☐ N ☐
11.Do your friends or relatives know or suspect you abuse drugs?.....Y ☐ N ☐
12.Has drug abuse ever created problems between you and your spouse?.....Y ☐ N ☐
13.Has any family member ever sought help for problems related to your drug use?.....Y ☐ N ☐
14.Have you ever lost friends because of your use of drugs?.....Y ☐ N ☐
15.Have you ever neglected your family or missed work because of your use of drugs?.....Y ☐ N ☐
16.Have you ever been in trouble at work because of drug abuse?.....Y ☐ N ☐
17. Have you ever lost a job because of drug abuse?.....Y ☐ N ☐
18.Have you gotten into fights when under the influence of drugs?.....Y ☐ N ☐
19.Have you ever been arrested because of unusual behavior while under the influence of drugs?...Y ☐ N ☐
20.Have you ever been arrested for driving while under the influence of drugs?.....Y ☐ N ☐
21.Have you engaged in illegal activities in order to obtain drug?.....Y ☐ N ☐
22.Have you ever been arrested for possession of illegal drugs?.....Y ☐ N ☐
23.Have you ever experienced withdrawal symptoms as a result of heavy drug intake?.....Y ☐ N ☐
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?.....Y ☐ N ☐
25.Have you ever gone to anyone for help for a drug problem?.....Y ☐ N ☐
26.Have you ever been in a hospital for medical problems related to your drug use?.....Y ☐ N ☐
27.Have you ever been involved in a treatment program specifically related to drug use?.....Y ☐ N ☐
28.Have you been treated as an outpatient for problems related to drug abuse?.....Y ☐ N ☐

A SHORT QUESTIONNAIRE ABOUT YOUR ALCOHOL USE

Have you ever thought you should CUT DOWN on your drinking? Y ☐ N ☐
Have you ever felt ANNOYED by others' criticism of your drinking? Y ☐ N ☐
Have you ever felt GUILTY about your drinking? Y ☐ N ☐
Do you have a morning EYE OPENER? Y ☐ N ☐