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11111 Hall Rd Suite 303
Utica, Mi 48317
www.wentworthandassociates.com
Phone # 586-997-3153 Fax # 586-997-4956

Life and History Health Questionnaire- Insurance and Emergency Data

Purpose of this questionnaire: The purpose of this questionnaire is to obtain a comprehensive picture of your background. In psychotherapy, records are necessary, since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. Please answer these routine questions in your own time, rather than using up your actual consulting time. If there are any questions that you prefer not to answer, merely write, "do not care to answer."

Name: _____ Today's Date: _____

Address: _____ Gender: _____

City, State, Zip: _____ Date of Birth: _____

Phone Number: _____ Email: _____@ _____

Social Security Number_____

How did you come to be referred to Wentworth and Associates, P.C.?

_____

Emergency Contact: Name_____ Relationship_____

Address_____ City: _____

State/ Zip code: _____ Phone Number_____

Primary Insurance Company:

_____

Effective date: _____ Contract/Member ID number:_____

Group number: _____ Provider Service Number:_____

Full name of subscriber: _____Relationship: _____

Subscriber's DOB: _____Subscriber's place of employment: _____

Secondary Insurance Company:

_____

Effective date: _____ Contract/ Member ID number: _____

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Group number: _____Provider Service Phone Number: _____

Full name of subscriber: _____ Relationship: _____

Subscriber's DOB: _____ Subscriber's place of employment: _____

Please describe the problem that brings you here:

_____

_____

_____

Tell us what goals you have for treatment in your own words:

_____

_____

_____

_____

When did your concern begin? _____

_____

Please select the word that describes the severity of your concern:

Mild Moderate Severe Extremely severe totally incapacitating

How do the concerns you are currently experiencing get in the way of your regular or daily functioning?

_____

_____

_____

_____

_____

How did the concerns you are experiencing interfere with your regular or daily functioning in the past?

_____

_____

_____

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This next section is designed to help you describe your current problems in greater detail and to identify problems that might otherwise go unnoticed. This will allow us to design a comprehensive treatment program that is tailored to your needs.

Please check all that apply to you.

- ☐ Overeating or bingeing
- ☐ Memory problems
- ☐ Fear of being in public (malls, restaurants, etc.)
- ☐ Many fears
- ☐ Rehashing things over and over in your mind
- ☐ Compulsive behaviors
- ☐ Impulsive reactions
- ☐ Difficulty concentrating
- ☐ Distractibility
- ☐ Can't get air
- ☐ Fear that people are talking about you
- ☐ Can't go to sleep
- ☐ Take drugs
- ☐ Vomiting
- ☐ Nausea
- ☐ Hearing things
- ☐ Work too hard
- ☐ Don't like being touched
- ☐ Intense or chronic guilt
- ☐ Shopping
- ☐ Feeling unsteady or shaky
- ☐ Unplanned early AM awakening
- ☐ Odd behavior
- ☐ Drink too much
- ☐ Seeing things
- ☐ Procrastination
- ☐ Suicidal attempts
- ☐ Nervous tics
- ☐ Irritability, grouchiness
- ☐ Unable to enjoy life
- ☐ Blackouts
- ☐ Dislike self
- ☐ Gambling
- ☐ Changes in sexual functioning
- ☐ Changes in sex drive
- ☐ Feel things are far away and unreal
- ☐ I go away in my mind for periods of time.

Please check any of the following that apply to you

- ☐ Pleasant sexual images
- ☐ Unpleasant childhood images
- ☐ Helpless images
- ☐ Aggressive images
- ☐ Images of being loved
- ☐ Lonely images
- ☐ Seduction images
- ☐ Unpleasant sexual images

Please explain

_____

_____

_____

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Please check any of the following that apply to you.

☐ I am worthless, a nobody, useless and/or unlovable ☐ Everything is against me ☐ People are out to get me	☐ I am crazy, degenerate, and/or deviant ☐ I am unattractive, incompetent, stupid, and/or undesirable	☐ I make too many mistakes, can't do anything right ☐ Life is empty, a waste, there is nothing to look forward to

Please explain:

_____

_____

_____

_____

What personal strengths do you have that will assist you in resolving the problems that bring you here?

_____

_____

_____

_____

As you see yourself now, what do you need to help you recover?

_____

_____

_____

_____

_____

Do you have any preferences about treatment that you would like us to consider?

_____

_____

_____

_____

_____

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Do you currently utilize any complementary modes of treatment (i.e. aromatherapy)?

Commented [LH1]:

_____

_____

Have you ever been hospitalized for emotional reasons? ☐ YES ☐ NO

Please give places, dates and circumstances:

_____

_____

_____

Have you had previous counseling? ☐ YES ☐ NO

Where, when and for what?

_____

_____

_____

Was it helpful? ☐ YES ☐ NO

Has anyone in your extended family or friendship circle ever ended their own life? ☐ YES ☐ NO

If yes please explain

_____

_____

_____

Does anyone in your family suffer from depression, anxiety, alcoholism, epilepsy, manic depression (i.e. bipolar disorder) or anything else that might be considered a mental disorder? ☐ YES ☐ NO

Please explain:_____

_____

_____

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Health Data

Physician _____Phone number _____

Date of last complete physical _____ Was blood work done? ☐ YES ☐ NO

Results _____

Are you currently being treated for any medical issues?

_____

Are you currently taking any prescribed medications? ☐ YES ☐ NO

If so, please list the medications and the dosages in the chart below.

Medication	Dosage	Length of time on medication	What symptom is this medication targeting	Who prescribed this medication? (Psychiatrist, OB Gyn, PCP)	Is the medication helping? If so what percent?	If you starting this medication recently are you feeling significantly worse?	Are you having any side effects?

Do you take over the counter medications? ☐ YES ☐ NO

If yes, what medications?_____

_____

How many hours of sleep do you usually average? _____

How would you describe the quality of your sleep? e.g. choppy, hard time falling asleep, hard time staying asleep, early morning awakening, other? _____

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Do you exercise? _____ If so what kind?_____

Do you eat balanced meals? _____ If no please explain: _____

Do you smoke, vape or use electronic cigarettes? _____ How much _____

Have you ever tried to become smoke free? _____ How many times? _____

What methods? _____

How many tea, coffee, or caffeinated soft drinks do you consume in a day?_____

Have you ever had trauma to the head or a closed head injury? ☐ YES ☐ NO

If yes, please explain: _____

_____

Is there anything related to your current sexual functioning and/or sexual orientation that you would like to discuss? _____

Have you ever been told that you had?

- ☐ Sickle cell disease
- ☐ Gout
- ☐ AIDS
- ☐ Asthma
- ☐ Heart Disease
- ☐ Rheumatic fever
- ☐ Diabetes
- ☐ Stroke
- ☐ Glaucoma
- ☐ Thyroid disease
- ☐ Anemia
- ☐ Bladder trouble
- ☐ Other serious communicable diseases such as TB
- ☐ Allergies
- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Cancer

What kind?

_____

- ☐ HIV
- ☐ Kidney disease
- ☐ Hepatitis A, B or C
- ☐ Emphysema
- ☐ Arthritis
- ☐ Ulcers
- ☐ Seizure disorder
- ☐ Low blood sugar

Do you currently have or have had in the past?

☐ Frequent headaches ☐ Numbness tingling	☐ Wheezing, gasping ☐ Blurred/double vison	☐ Bloody/coffee colored urine

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☐ Frequent urination	☐ Skin rashes	☐ Dental problems
☐ Coughing up blood	☐ Difficulty starting urination	☐ Bowel Disturbances
☐ Hearing difficulty	☐ Hot flashes or chills	☐ Rectal bleeding or unusual painful discharge
☐ Tics, twitches	☐ Many chest colds	☐ Convulsions, feeling shaky or trembling
☐ Vomiting blood	☐ Swollen feet or ankles	
☐ Faintness, dizziness	☐ Shortness of breath	
☐ Diarrhea	☐ Worsening of eyesight	
☐ Sexual disturbances	☐ Muscle spasms	
☐ Frequent coughing	☐ Night sweats	

Please explain any you have checked:

_____

_____

_____

_____

History of chemical/alcohol use

Are there heavy drinkers in your family or origin? ☐ YES ☐ NO

Do you consider yourself a "normal" drinker? ☐ YES ☐ NO

Have you ever driven while intoxicated? ☐ YES ☐ NO

If so please explain:

_____

_____

Has anyone expressed concern over your drinking or use of drugs? ☐ YES ☐ NO

Please explain?

_____

_____

_____

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Have you had treatment for alcohol or other chemical dependency? ☐ YES ☐ NO

If so where and when?

_____

_____

_____

Please check any of the following recreational chemicals that you have used:

	Past	Current
Abuse of over the counter meds	☐	☐
Alcohol	☐	☐
Amphetamines	☐	☐
Barbiturates	☐	☐
Cocaine	☐	☐
Crack	☐	☐
Crystal Meth	☐	☐
Ecstasy	☐	☐
Hallucinogens	☐	☐
Heroin	☐	☐
Inhalants	☐	☐
Marijuana	☐	☐
Painkillers	☐	☐
Sedatives	☐	☐
Tranquilizers	☐	☐
Other	☐	☐

How many times per week do you drink or use chemicals? _____

How many drinks or how much substance do you use per occasion? _____

Marital Status:

Single Married Separated Widowed Divorced Living together
In committed relationship

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What is the length of your marriage/relationship?

_____

On a scale of 1 - 10 (1-low, 10-high) what is the level of commitment to staying with your partner today?

1 2 3 4 5 6 7 8 9 10

Family members:

Name	Relationship	Age	Health	Living with You

How would you describe the quality of your family relationships?

_____

_____

What supportive relationships do you have in your life?

_____

_____

_____

How many times have you or your partner been pregnant?

_____

How many children do you have?

_____

Current spiritual preference: _____

Raised:_____

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If not active, is there a particular reason?

_____

_____

Legal Data:

- ☐ Traffic Tickets
- ☐ Lawsuits against others
- ☐ Relatives or loved ones with serious problems with the law
- ☐ Misdemeanors
- ☐ Lawsuits against you
- ☐ Felonies
- ☐ Bankruptcy

Military Data: Active Duty ☐ YES ☐ NO What Branch? _____

Type of discharge? _____

Did any of the following apply to your childhood or adolescence?	☐ Happy Childhood ☐ Family Problems ☐ Severe Illness ☐ Sexual Abuse ☐ Unhappy Childhood ☐ Strong religious convictions	☐ Traumas (death of family member, natural disaster, etc.) ☐ Sexually inappropriate behavior ☐ Emotional problems ☐ Drug Abuse ☐ Legal troubles ☐ Medical problems	☐ Behavioral problems ☐ Alcohol Abuse ☐ Physical abuse ☐ Emotional abuse ☐ School problems

Birth Order _____ Siblings _____

Cultural Identification _____

Relationship with siblings and parents: _____

Parents relationship: Divorces? ☐ Yes ☐ No Parental separation ☐Yes ☐No

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What was your response to parental conflict

_____

_____

_____

Process of separation/emancipation from parents:

_____

_____

History of	☐ Emancipation ☐ Left home as a minor ☐ Abandonment ☐ Neglect ☐ Adoption ☐ Removal from Home ☐ Deaths ☐ Physical Abuse ☐ Sexual Abuse

Do you make friends easily? ☐ YES ☐ NO Do you keep them? ☐ YES ☐ NO

Were you ever bullied or severely teased? _____ When? _____

For what?

_____

_____

Describe any relationship that gives you joy:

_____

_____

_____

Describe any relationship that gives you grief: _____

_____

_____

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Have you been exposed to accidents and/or traumas as an adult that effect your life now? ☐ YES ☐NO

If so, please explain: _____

_____

_____

What do you do for fun and relaxation?_____

_____

_____

Any changes in this recently? _____

_____

Education:

- ☐ High School Graduate From where? _____
- ☐ GED From where? _____
- ☐ College Which school? _____
- ☐ How many years? _____ How many credits? _____

Work History:

What do you do?

_____

How many hours per week do you work?

_____

Shift work? ☐ YES ☐ NO

Other work you have done:

_____

_____

What would you like to do?

_____

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Where do you see yourself in terms of work in the next 5 years? _____

_____

_____

Childhood Developmental and Educational History

Please answer based on information you have about your childhood

Complications due to pregnancy or delivery	☐ Yes ☐ No
Prenatal Exposure to drugs or alcohol	☐ Yes ☐ No
Birth defects of handicap	☐ Yes ☐ No
Walking, talking, and toilet training on time	☐ Yes ☐ No
What kind of temperament as a child	☐ Easy ☐ Slow to warm up ☐ Difficult
Schools	☐ Public ☐ Parochial ☐ Private

Current Grade _____

History of Hyperactivity or ADD	☐ Yes ☐ No ☐ Diagnosed ☐ Undiagnosed
Medication?	☐ Past ☐ Present Dosage _____

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History of Learning disabilities	☐ Yes ☐ No What subjects? _____ _____
History of special education	☐ Yes ☐ No In what grade? _____
Resource room?	☐ Yes ☐ No
T.C?	☐ Yes ☐ No
History of ?	☐ Suspensions ☐ Expulsions ☐ Being held back? Grade _____ ☐ Being accelerated? Grade _____ ☐ Peer ridicule? Reason? _____
Behavioral Problems	☐ Home ☐ School
Nature of Problems	_____ _____ _____ _____

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Please check any of the following words that you might use to describe yourself.

- ☐ Intelligent
- ☐ Ambitious
- ☐ Trustworthy
- ☐ Useless
- ☐ Crazy
- ☐ Deviant
- ☐ Confused
- ☐ Naïve
- ☐ Horrible Thoughts
- ☐ Hardworking
- ☐ Persevering
- ☐ Confident
- ☐ Sensitive
- ☐ Full of regrets
- ☐ Honest
- ☐ Conflicted
- ☐ Can't make decisions
- ☐ Good sense of humor
- ☐ Worthwhile
- ☐ Loyal
- ☐ Worthless
- ☐ Evil
- ☐ Considerate
- ☐ Unlovable
- ☐ Stupid
- ☐ Incompetent
- ☐ Attractive
- ☐ Suicidal ideas

Negative Cognitions: We all have negative cognitions or self-talk at times. Please review the list of common negative self-statements below. Check those statements that you OFTEN say to yourself. They may not be true, but you may feel this way at times or say these things to yourself.

Thoughts of defectiveness or responsibility

- ☐ I am not good enough
- ☐ I am incompetent
- ☐ I am not lovable
- ☐ I am ugly/my body is hateful
- ☐ I am insignificant/unimportant
- ☐ I deserve to be miserable
- ☐ I have to be perfect (out of inadequacy)
- ☐ I don't deserve love
- ☐ I am worthless/inadequate
- ☐ I deserve only bad things
- ☐ I do not deserve
- ☐ I am a disappointment
- ☐I am different/don't belong
- ☐ I am a bad person
- ☐ I am shameful
- ☐ I am permanently damaged
- ☐ I am stupid/not smart enough
- ☐ I deserve to die

Thoughts concerning Responsibility or Action

- ☐ I should have done something
- ☐ What does this say about you? E.g. I am shameful/ I am stupid/ a bad person
- ☐ I did something wrong
- ☐ I am inadequate or weak
- ☐ I should have known better

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Thoughts concerning safety/vulnerability

- ☐ I cannot trust anyone
- ☐ I am not safe
- ☐ I cannot protect myself
- ☐ I am going to die
- ☐ I am in danger
- ☐ It's not ok(safe) to feel/show my emotions

Thoughts concerning power and control

- ☐ I am not in control
- ☐ I cannot stand up for myself
- ☐ I cannot trust myself
- ☐ I cannot succeed
- ☐ I am powerless/helpless
- ☐ I cannot let it out
- ☐ I cannot trust my judgement
- ☐ I have to be perfect/please everyone
- ☐ I cannot get what I want
- ☐ I cannot be trusted
- ☐ I am a failure/will fail
- ☐ I can't handle it (I am out of control)

Are you currently being physically, emotionally or sexual abused?

_____

Please explain:_____

_____

Safe-T Assessment

1.) Risk Factors (Please check any that apply)

	None		**Past Attempts**
	Rehearsals		**Self Harm**
	Impulsivity		**Hopelessness**
	Panic Attacks		**Insomnia**
	Academic Issues		**Family Issues**
	Major Trauma		**Vocational Issues**
	Changes in psychological treatment i.e. discontinuation, reduction in frequency, medication changes etc.		**Financial Issues**
	Access to weapons, sharp objects, medications		**Substance/ Alcohol abuse**
	Family/ friend history of suicide		

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2.) Protective Factors(please check any that apply)

	None		**Ability to cope with stress**
	Frustration tolerance		**Absence of psychosis**
	Positive therapeutic relationship		**Social supports**

3.) Suicide Inquiry (please check any that apply)

	None		**Thoughts in the last 48 hours**
	Planned time		**Planned Place**
	Availability of means		**Preparations being made**
	Believe plan is lethal		**Believe plan is self-injurious**
	Reasons to die		

(SBQ-R Suicide Behaviors Questionnaire)

Have you ever thought about or attempted to kill yourself? (check one only)

☐ Never

☐ It was just a brief passing thought

☐ I have had a plan at least once to kill myself but did not try to do it

☐ I have had a plan at least once to kill myself and really wanted to die

☐ I have attempted to kill myself, but did not want to die

☐ I have attempted to kill myself, and really hoped to die

How often have you thought about killing yourself in the past year? (check only one)

☐ Never

☐ Rarely (1 time)

☐ Sometimes (2 times)

☐ Often (3-4 times)

☐ Very Often (5 or more times)

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Have you ever told someone that you were going to kill yourself or that you might do it? (check only one)

☐ No

☐ Yes, at one time, but did not really want to die

☐ Yes, at one time, and really wanted to die

☐ Yes, more than once, but did not want to do it

☐ Yes, more than once, and really wanted to do it

How likely is it that to will attempt suicide someday? (check one only)

☐ Never

☐ No chance at all

☐ Rather unlikely

☐ Unlikely

☐ Likely

☐ Rather Likely

☐ Very Likely

Please check any that apply

- ☐ I do not feel I fit in or belong anywhere
- ☐ I feel like I am a burden to my family or society
- ☐ I have no qualms or fears of harming myself

Have you ever seriously considered killing someone else?

- ☐ In the past
- ☐ Currently, if so whom? _____

  How_____

Please explain:_____

_____

Do you or anyone in your home own a firearm? ☐ YES ☐ NO

Additional Comments:

_____

_____

_____

_____

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ACE- Adverse Childhood Experiences:

1.) Did a parent or other adult in the household often or very often…..Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?

☐Yes ☐No

2.) Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

☐Yes ☐No

3.) Did an adult or person at least 5 years older than you ever…..Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal or vaginal intercourse with you?

☐Yes ☐No

4.) Did you often or very often feel that…..No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

☐Yes ☐No

5.) Did you often or very often feel that…..You didn't have enough to eat, had to wear dirty clothes, had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

☐Yes ☐No

6.) Were your parents ever separated or divorced?

☐Yes ☐No

7.) Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

☐Yes ☐No

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

☐Yes ☐No

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

☐Yes ☐No

10.)Did a household member go to prison?

☐Yes ☐No

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Do you have an Advance Directive? (for more information on Advance Directives and planning for important Health Care Decisions go to www.caringinfo.org) Yes or No

Client Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

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PRACTICE ORIENTATION AND AGREEMENT
YOUR RIGHTS AND RESPONSIBILITIES AS A CLIENT

*** You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.**
*** You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.**
*** You have the right to privacy and confidentiality regarding the service you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act.**
*** You have the right to informed consent for services offered to you.**
*** Your clinician is responsible for all service coordination.**
*** You have the right to refuse services at any time. You have the right to withdraw your consent to receive services and discontinue services at any time. You have a right to information concerning your treatment/care.**
*** You have the right to know treatment recommendations and the possible outcomes if you choose not to follow these recommendations.**
*** You have the responsibility to assist in planning your treatment at every stage.**
*** You have the right to express any concerns or complaints regarding the services you receive. We encourage you to first contact your clinician to resolve any issues. You may also contact the Rights Advisor and Office Manager, Laura Hitt, for assistance. A description of how to register a concern is posted in our lobby and on our website.**
*** You have the responsibility to be timely for your appointments. Late arrivals may result in rescheduled appointments.**
*** You have the responsibility to arrive for all scheduled sessions, or to notify us 24 hours in advance if you wish to cancel an appointment. You may be charged a practice fee, up to $125, for non-cancelled or late cancelled appointments, when an emergency was not involved, because insurance companies and other third-party payers do not cover missed appointments.**
*** You are responsible for any fees that may be charged to you at the time of service and, also, for knowing your insurance benefits coverage. We check benefits as a courtesy, but this is NOT a guarantee of coverage.**
*** Your case will be closed following 45 days of inactivity, unless other arrangements have been made.**
*** You have the right to know we may call the police if someone comes to the practice under the influence of drugs or alcohol and tries to leave the practice driving a motor vehicle.**
*** You have the right to know that no member of our staff is allowed to date or have a personal relationship with current or former clients of the practice.**
*** You have the right to know that staff and therapists are not allowed to accept gifts from clients of the practice, nor are they permitted to enter into any business relationships of any kind with you.**
*** You have the responsibility to conduct yourself in a non-disruptive and non-aggressive manner while on the premises. Wentworth &Associates will never use restraints but emergency responders will be called if necessary.**
*** If we are treating your minor child our policy is to make a concerted effort to engage both parents in the therapeutic process.**

Reasons your treatment may be terminated:

- **Being under the influence of any illegal substance while on the premises**
- **Threatening the safety or rights of any client or staff member**
- **Non-compliance with treatment or an inability of the facility to provide you the care you require**
- **You have two or more subsequent late cancellations (under 24 hours' notice), or two or more failures to appear at a scheduled appointment without notice.**

***In all instances, you have the right to a referral for a different treatment option**

SERVICES OFFERED

Wentworth and Associates offers an array of mental health services. These services include: individual psychotherapy, group therapy, family therapy, marital therapy, psychological testing, Psychiatric evaluations and medication therapy are also available on site. Your clinician will provide you with a detailed description of the nature of services and expected benefits and potential risks.

CLIENT INPUT

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Wentworth and Associates will be asking you for ongoing feedback regarding the quality and effectiveness of services you receive. We will ask you to complete clinical outcome questionnaires and satisfactions surveys periodically. We will also review and/or investigate any complaints or suggestions you may have (contact Rights Advisor). Your feedback is considered an important part of treatment/care.

OPERATIONS

Office hours are usually between 7AM and 10PM, 7 days a week. Not all clinicians are available during all open hours. Appointment dates and times and after hours' contacts shall be arranged between you and your treating clinician. An indoor elevator is located in the front lobby of the building for individuals with physical disabilities. In emergencies, you can contact the nearest crisis center (Macomb County Crisis Center at 586-307-9100; Oakland Crisis Center at 248-456-0909). You may also contact or go to the nearest emergency room. We practice in a non-smoking, non-vaping environment. illicit drugs and weapons are not allowed on the premises. Persons in possession of either will be asked to leave immediately.

CONFIDENTIALITY

Federal and State laws protect the privacy of communications between a client and a clinician. In most situations, release of information about your services/treatment to others can only be done if you sign a written Authorization to Release that meets certain legal requirements. Also, there are some limits to confidentiality, such as if you intend to harm yourself or others.

Information about privacy and limits to confidentiality will be provided by your primary clinician and is also provided in our Notice of Privacy Practices. STATE LAW REQUIRES REPORTING OF SUSPECTED CHILD ABUSE/NEGLECT, ELDER ABUSE.

FINANCIAL RESPONSIBILITY

You are expected to pay for service at the time it is rendered, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. A fee adjustment or a payment installment plan may be negotiated in circumstances of unusual financial hardship. All clients will be informed of payment fee schedules prior to rendering services. Although we are likely to inform you of your insurance deductible and co-pays (if any), you are ultimately responsible for knowing this information and for paying both in full. ***A $25 charge may be required for returned checks. You may be charged up to $25.00 if you request records to be sent out. If your client balance exceeds $200.00 service may be suspended, and you will be offered a referral to another clinic where you will be able to continue your treatment.***

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, legal action may be used to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require disclosure of otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim.

If I am paying privately, based on my ability to pay, I agree to pay_____ for an Intake Evaluation, _____ for Individual Therapy, _____Family Therapy, _____ for Testing and _____ for Extended Sessions.

MINORS & PARENTS

Clients under 18 years of age who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that clients over age 14 can consent to (and control access to information about) their own psychosocial treatment, although that treatment cannot extend beyond 12 sessions or 4 months. While privacy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is Wentworth and Associates policy to request (but not require) an agreement from any client between 14 and 18 and his/her parents allowing to share general information with parents about the progress of treatment and the child's attendance at scheduled sessions.

FAMILY INVOLVEMENT IN TREATMENT

While family treatment may be useful at times, involvement of family members is to be negotiated with the client and therapist. Unless family therapy is warranted and all member consent to treatment, it is up to the client and therapist to

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determine the level of family (or other persons) involvement in sessions. In any case, the therapist may not release any information to anyone regarding the client without the client's written consent. In the case of minors, it is strongly suggested to keep most of the client's treatment between the client and therapist and only involve family members in treatment when necessary.

CONSENT FOR CASE CONFERENCING
I hereby give my informed consent to have my case presented at case conferencing or group supervision meetings at Wentworth and Associates, PC only.
I understand that my therapist will make every effort to protect my confidentiality and will not be using names or other specific identifying information. I understand that the purpose of presenting my case at these case meetings is to get a multidisciplinary team approach in order to improve my treatment.
I understand that any clinical staff person or student may attend these meetings and that they are facilitated by the CEO, Dr. Lawrence T. Wentworth, PhD, Licensed Psychologist.
I understand that the staff members are not liable in any way for treatment suggestions, case conceptualizations or recommendations made to my therapist in an effort to improve my care.
I understand that I may revoke my authorization at any time.
Please check one:
I consent to have my case discussed in case conferencing _____
I DO NOT consent to have my case discussed in case conferencing _____

My initials below indicate that I:
_____ Have been made aware of my rights and responsibilities and how to file a grievance or complaint
_____ Have been informed of the name, discipline, and credentials of my primary clinician
_____ Have been informed of practice-specific information and given an orientation to services including fees
_____ Have been informed of privacy practices, confidentiality, and limits to confidentiality (including limits in use of electronic communication such as emails, text etc.)
_____ Have been informed of all the emergency evacuation procedures of the practice and its premises.
_____ Have received a copy of the LARA recipients rights brochure and have reviewed it with my therapist.

My signature below indicates that I consent to receive services at Wentworth and Associates, and that I understand I may discuss any questions I have regarding services and that I maintain the option to terminate my consent at any time.

_____ _____
Client Signature Date Client's Name Printed

_____ _____
Signature of Client's Representative Date Wentworth & Associates, PC Staff Signature Date

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OQ 30
Self Report Questionnaire – Adult

Name: _____ Therapist: _____ Date: _____

Instructions: Looking back **over the last week*, including today*,** help us understand how you have been feeling. Read each item and mark (☑) the answer that best describes your current situation. For this questionnaire, **"work"** is defined as employment, school, housework, volunteer work, and so forth.

1. I have trouble falling asleep or staying asleep.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

2. I feel no interest in things.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

3. I feel stressed at work, school, or other daily activities.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

4. I blame myself for things.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

5. I am satisfied with life.
O 4 Never O 3 Rarely O 2 Sometimes O 1 Frequently O 0 Almost always

6. I feel irritated.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

7. I have thoughts of ending my life.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

8. I feel weak.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

9. I find my work, school, or other activities satisfying.
O 4 Never O 1 Rarely O 2 Sometimes O 1 Frequently O 0 Almost always

10. I feel fearful.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

11. I use alcohol or drugs to get going in the morning.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

12. I feel worthless.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

13. I am concerned about family troubles.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

14. I feel lonely.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

15. I have frequent arguments.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

16. I have difficulty concentrating.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

17. I feel hopeless about the future.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

18. I am a happy person.
O 4 Never O 3 Rarely O 2 Sometimes O 1 Frequently O 0 Almost always

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19. Disturbing thoughts come into my mind that I cannot get rid of.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
20. People criticize my drinking (or drug use).
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
21. I have an upset stomach.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
22. I am not working or studying as well as I used to.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
23. I have trouble getting along with friends and close acquaintances.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
24. I have trouble at work/school because of drinking or drug use.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
25. I feel that something bad is going to happen.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
26. I feel nervous.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
27. I feel that I am not doing well at work/school.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
28. I feel something is wrong with my mind.
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
29. I feel "blue".
O 0 Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
30. I am satisfied with my relationships with others.
O 4 Never O 3 Rarely O 2 Sometimes O 1 Frequently O 0 Almost always

Wentworth and Associates Issue Specific Questions

1. Please list the issue that prompted you to seek treatment: _____

2. Regarding this issue, how much distress is it causing you at this time? Please circle the number that corresponds to your level of distress:

No distress 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 A lot of distress

3. Please rate your level of satisfaction with the treatment you have received at Wentworth and Associates thus far.

No treatment 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Very Satisfied

Staff Use:
Check One
___ Intake Assessment
___ Quarterly Assessment
___ Discharge Assessment

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Patient's name:_____

DOB _____/_____/_____

SSN#_____-_____-_____

Wentworth & Associates, P.C.
COORDINATION OF CARE CONSENT FORM

I,_____hereby ____authorize___ do not authorize Wentworth & Associates, P.C. to release and/ or obtain confidential information ____my child's/ward's patient records to and from the following physician(s): (Info Primary Care Physician, check here___ and sign below.)

My Primary Care Physician_____

Physician's Name

Address or Fax Number _____

Information to be disclosed:

___ Diagnoses_____

___Medical Information_____

___Assessments/Testing Information_____

___Other_____

Instructions/Requests:_____

_____

Purpose of such disclosure:

___ Coordination of Care_____

___Other_____

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Witness Signature_____Date_____

The use of this consent by Wentworth & Associates, P.C. is effective for one year from the date of signature, and may be revoked by myself, in writing at any time. This consent is being signed voluntarily and under no circumstances is a precondition of treatment.

Date Condition or Event for Revocation of this form_____

Please send requested information to:_____

Wentworth and Associates, P.C. Requesting Clinician's name
11111 Hall Rd Suite 303 or fax to (586) 997-4956
Utica, MI 48317
This form was __ Mailed ___ Faxed ____ other (Specify) to the PCP above
Original: Clinical record Copy: Primary Care Physician Rev 02/09/2016

Note: For your child's protection, children under the age of 12, MUST be accompanied by an adult in our waiting rooms

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GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS AND SERVICES

Wentworth and Associates, P.C.
11111 Hall Road, Suite 303

Phone (586) 997-3153
Fax (586) 997-4956
Wentworth

Wentworth and Associates
NPI 1306827191
Tax ID 38-3284673

Client Information:

*** First Name _____**

*** Last Name _____**

*** Date of Birth _____/_____/_____**

*** Address _____**

*** City and State _____,_____**

*** Zipcode _____**

*** Phone Number ( )_____-_____**

***Email Address_____**

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*** Patient's Contact Preference (please check one) phone:___ text:___ email:___**

The primary services at Wentworth and Associates are Psychotherapy. The common billable codes and estimated fees are as follows:

CPT Codes	Cost Per Session
90791	$212.00
90832	$91.00
90834	$121.00
90837	$179.00
90846	$148.00
90847	$120.00
90792	$200.00
99213	$90.00

Disclaimer
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.
*This is only an estimate and actual services, and charges may differ
Separate estimates will be issued upon request for services that are in consideration of being provided by other Wentworth and Associates staff members. There may be other services required that must be scheduled separately during the course of treatment and are not included in the estimate.
The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

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If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.
You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.
You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.
There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.
To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call (586) 469-7700 for the State of Michigan Department of Health and Human Services.
For questions or more information about your right to a Good Faith Estimate and/or the dispute process, visit www.cms.gov/nosurprises or call (586) 469-7700 for the State of Michigan Department of Health and Human Services.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

By typing my name I am acknowledging that I have received the Good Faith Estimate from my therapist. My therapist and I have discussed the potential charges and which procedure codes I can expect to be billed going forward. I understand that my insurance is not in network with Wentworth and Associates and I can expect to be billed the out of network charges stated above.

I understand that I can request a copy of this Good Faith Estimate at any time.

Client or Guardian Signature _____

Client or Guardian Printed Name:_____

Date: / /