Sunshine State
COUNSELING CENTER

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy. This questionnaire will take approximately 30 minutes to complete.

Client Information

Last Name: _____ First Name: _____ Initial: _____

Birth date: ____ / ____ / ____ Age: _____ Gender: ☐ Male ☐ Female

Child's School: _____ Teacher's Name _____ Child's Grade: ____

Is child in special education? ☐ Yes ☐ No If so, what type? _____

Is child adopted? ☐ Yes ☐ No If yes, at what age? _____

Address: _____ City: _____ State: ____ Zip: _____

Parent or Guardian

Last Name: _____ First Name: _____ Initial: _____

Birth date: ____ / ____ / ____

Address if not the same as above

Address: _____ City: _____ State: ____ Zip: _____

Parent/Guardian Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home phone: _____ May we leave a message? ☐ Yes ☐ No

Cell / Other: _____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we email you?* ☐ Yes ☐ No *NOTE: Emails may not be confidential

Parent or Guardian

Last Name: _____ First Name: _____ Initial: _____

Birth date: ____ / ____ / ____

Address if not the same as above

Address: _____ City: _____ State: ____ Zip: _____

Parent/Guardian Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home phone: _____ May we leave a message? ☐ Yes ☐ No

Cell / Other: _____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we email you?* ☐ Yes ☐ No *NOTE: Emails may not be confidential

Please list all other children (including step and foster children) in the family

Name: _____ Age: _____ Grade: _____ Living in Home? ☐ Yes ☐ No

Name: _____ Age: _____ Grade: _____ Living in Home? ☐ Yes ☐ No

Name: _____ Age: _____ Grade: _____ Living in Home? ☐ Yes ☐ No

Referred by: _____

Client Mental Health and General Health Information

Is your child currently / has your child ever received psychological services, professional counseling, psychiatric services, or any other mental health services? ☐ Yes ☐ No Reason for change: _____

Is your child currently taking any psychiatric prescription medication? ☐ Yes ☐ No

If yes, please list: _____

Has your child been prescribed psychiatric prescription medication in the past? ☐ Yes ☐ No

If yes, please list: _____

Primary Care Physician: _____ Phone: _____

How is your child's physical health at the present time? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, asthma, etc.):_____

_____

Is your child on any medication for physical/medical issues? ☐ Yes ☐ No

If yes, please list: _____

Is your child having any problems with sleep? ☐ Yes ☐ No

If yes, select those that apply: ☐ Sleep too much ☐ Sleep too little ☐ Poor quality ☐ Disturbing dreams

Other: _____

Are there any changes or difficulties with your child's eating habits? ☐ Yes ☐ No

If yes, select those that apply: ☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting ☐ Other: _____

Has your child experienced a weight change in the last two months? ☐ Yes ☐ No

If yes, select those that apply: ☐ Gain of weight ☐ Loss of weight ☐ Other: _____

Chief Complaint: Please explain your present concerns about your child and what you think is causing the problem: _____

_____

Onset: When did you first notice the concern / problem? What else was happening at that time that might be important? _____

_____

What have you already tried in order to solve the problem? _____

_____

Family Health and Mental Health History

Please list any family medical conditions: _____

The following is to provide information about your family mental health history. Check any that apply. If checked, please indicate the family member affected.

- ☐ Depression _____
- ☐ Bipolar Disorder _____
- ☐ Alcohol/Substance Abuse _____
- ☐ Learning Disability _____
- ☐ Domestic Violence _____
- ☐ Obsessive Compulsive Behavior _____
- ☐ Anxiety Disorders _____
- ☐ Panic Attacks _____
- ☐ Eating Disorder _____
- ☐ Trauma History _____
- ☐ Obesity _____
- ☐ Schizophrenia _____

Other: _____

Current Symptom Checklist

Please place a check mark in the box next to any symptom you have observed or your child has reported in the past few weeks.

- ☐ Nightmares or night terrors
- ☐ Feel a sense of dread
- ☐ Feel I have no future
- ☐ Isolation / social withdrawal
- ☐ Mood swings
- ☐ Agitation or nervousness
- ☐ Muscle tension or soreness
- ☐ Stomach nausea or upset
- ☐ Having to check and re-check
- ☐ Worry about what others think
- ☐ Compare self to others
- ☐ Obsessive thoughts
- ☐ Compulsive behaviors
- ☐ Feel my life is out of control
- ☐ Afraid something is wrong with me
- ☐ Faintness or dizziness
- ☐ Easily annoyed or irritated
- ☐ Pain in heart or chest
- ☐ Feel over-sensitive
- ☐ Dislike crowds
- ☐ Difficulty remembering things
- ☐ Feel suicidal
- ☐ Low self-esteem
- ☐ Avoid certain things
- ☐ Have frightening / disturbing thoughts
- ☐ Feel something bad will happen
- ☐ Fears / Phobias
- ☐ Worry a lot
- ☐ Feel hopeless / helpless
- ☐ Appetite changes
- ☐ Excessive behaviors (spending, gambling, etc)
- ☐ Racing thoughts
- ☐ Frequent headaches
- ☐ Feel panicky or terrified
- ☐ Uncomfortable memories
- ☐ Feel disconnected from reality
- ☐ Dislike my body
- ☐ Feel guilty or ashamed
- ☐ Cry often
- ☐ Feel life is not worth living
- ☐ Temper outbursts
- ☐ Heart pounds or races
- ☐ Feel inferior to others
- ☐ Difficulty making decisions
- ☐ Afraid to go out in public
- ☐ Feel worthless
- ☐ Argumentative
- ☐ Low energy
- ☐ Withdrawn socially
- ☐ Body aches and pains
- ☐ Feel lonely
- ☐ Perfectionist
- ☐ Shortness of breath
- ☐ Enjoy things less
- ☐ Self-conscious
- ☐ Fearful when driving
- ☐ Trouble concentrating
- ☐ Stress or tension
- ☐ Thoughts of hurting yourself
- ☐ Thoughts of hurting someone
- ☐ Cutting or self-injury
- ☐ Alcohol or drug use
- ☐ Prescription drug abuse
- ☐ Anger management
- ☐ Blackouts
- ☐ Depression/sadness

Please list any other symptoms that would be helpful to know: _____

Confidentiality

In working with child clients, though legally the parent(s) or legal guardian(s) of the child is the client, age appropriate privacy is essential in the therapeutic relationship and setting for a child's therapy, we do honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.

In working with couples and families, the couple as an entity and the family as an entity is the client and we are not providing individual therapy for either individual in the relationship or for any one member of the family although sessions with individuals in the couple/family may be a part of the couples/family therapy. We will not be a "secret keeper" nor facilitate secret keeping. If anything significant is revealed in an individual session that your therapist feels the other party needs to be told, your therapist will require it be brought up in the next session together so we can work through it or counseling may have to be ended with a referral to another therapist.

In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of our profession. There are some exceptions as follows:

Limits to Confidentiality:

1. If you make a serious threat to harm yourself or another person, the law requires us to try to protect you or that other person by informing appropriate authorities.
2. If we have reason to believe a child or any adult dependent has been or will be abused or neglected, we are legally required to report this to the proper authorities.
3. If you are or will be involved in court proceedings and the records are ordered by a judge.
4. If a guardian ad litem (GAL) is appointed in a custody case involving child clients and she/he is ordered by the court to have access to mental health practitioners and records therein.
5. The Patriot Act of 2001 requires us in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits us from disclosing to our clients that the FBI sought or obtained the items under the Act.
6. In professional supervision or consultation with other therapists; Shared office space, record storage and voicemail system with a fellow therapist. Peers, fellow therapists and any supervisor are bound by confidentiality as well.
7. Email, texting and voice phone communications cannot be guaranteed confidential. Please do not leave private health information in email, text or voicemail.
8. In the case of death or incapacitation, all clients will be contacted and records will be accessed by a designated mental health professional who will ensure confidentiality.
9. In the case we need to collect unpaid payments, a collection agency may be utilized.

Clinical Record

You should be aware that, pursuant to HIPAA, we keep information about all of clients in a collection of professional records. This constitutes your Clinical Record. There will be an administrative fee of $95 charged for preparing the record for release upon your written request.

Complaints or Grievances

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services we are providing, we invite you to first communicate your concerns to us directly so that we will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about us with our licensing board and may do so by contacting the board at the following address and phone number:

Florida Board of Clinical Social Work, Marriage & Family Therapy
and Mental Health Counseling Department of Health
850-245-433
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3260

Email Policy:

We will communicate with clients through email only about scheduling and payment issues. There is a charge for time spent reading emails that goes beyond brief exchanges about scheduling and payment issues. Please see fee outlines.

Voicemail Policy:

Voicemail is checked throughout the week unless on vacation or out of country for any reason. Therapists are not available when in session with other clients. We cannot guarantee absolute confidentiality with regard to phone service. Voicemail is password protected and secure to the best of ability. Please do not leave sensitive or detailed information in voicemail for protection of your privacy.

Vacation/Travel Policy:

When away from the office for vacation or business travel and unable to access voicemail and/or email your therapist will notify you in advance and will designate a professional counselor colleague to be on call in case of urgent and emergency issues.

Social Media Policy:

In order to protect your confidentiality we cannot accept friend or connection requests from clients on any social media platform. You may follow social media accounts that are open to the public but please do not comment in a way that will identify yourself as a client. If you do, your comments will be deleted and we will discuss in person at our next session.

Divorce and Custody Cases

We are not custody evaluators and cannot make any recommendations on custody. We can refer you to a list of evaluators who provide custody evaluation if needed.

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, we have very specific policies to which you must agree before we enter a counseling relationship:

1. We require a copy of any standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session. We need to have contact and written/signed consent with/from both legal guardians before we see the child for counseling.
2. We will provide a one hour interview with any court-ordered Guardian ad Litem whom the court has ordered will have access to the child's records and that session time will be paid by the parents.
3. We will be in equal contact with both parent who share in the legal custody of the child being seen for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.
4. Family sessions will likely be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.
5. We require all clients waive right to subpoena any of our therapists to court. This policy is set in order that we can preserve the integrity of the therapeutic progress and relationship with you and/or your child(ren).
6. In the case this policy is waived or disregarded and we are subpoenaed to appear in court even with this waiver – you will be charged the full standard fee for Court Related work of $250/hour for professional time. Any time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand, as well as any travel time will also be billed at $250 per hour. Any reduced fee previously granted will not apply to court related work.

Session Parameters

- All initial Intake Sessions are 60 minutes.
- Individual Sessions are 60 minutes.
- Parenting Sessions are 60 minutes.
- Couples Counseling and Family Counseling Sessions are 60 minutes.
- Self-pay clients have the option of scheduling an additional 30 minutes for Parenting Sessions, Couples Counseling, and Family Counseling Sessions (total of 90 minutes) for an additional fee.
- Sessions will start and end on time. If you arrive late, the session will still end at the orignially scheduled end time.

Fees, Payment, Insurance

Therapists may be out of network mental health providers. At the end of each month, upon your request, we will submit a statement to file with your insurance company for out of network reimbursement.

There is a $25 fee for any returned checks. That $25 fee is due at the time of your next session, along with the payment for that session. If a check is returned for insufficient funds, we will require that you pay using cash or credit card only from that point on. We accept MasterCard, Visa, American Express, and Discover.

**Checks should be made out to Sunshine State Counseling Center.

Please be advised that the fee for service is due at the time the service is rendered. If a child client is being seen, please be discreet in submitting payment and we ask that you never have the child involved in the payment process.

Fee Structure **(Self-pay):**

- Initial Intake Session (60 minutes): $175
- Couples or Family Therapy Sessions (90 minutes long): $175
- Individual Therapy Services (60 minutes): $125
- Parent Session (60 minutes): $125
- Email Counseling (anything other than brief updates and document exchange that requires us writing or reading more than 3-4 sentences): $35/exchange or $80 for 4 exchanges in one string of emails within 48 hours
- Phone Sessions (anything over 10 minutes on the phone initiated by the client): $50/25 minutes or
- Preparation of Summaries of Treatment or Letters at request of client: $95 per item requested.
- Court Related and/or Child Specialist Work for Collaborative Law Cases: $250/hour of any and all time spent on the case.
- Administrative Fee for Record Copy Requests: $95
- Check Return/Insufficient Funds Fee: $25

After Hour Support and Emergencies

Sunshine State Counseling, LLC is not an emergency services agency. We do not provide emergency services. If you have a life threatening emergency you should call 911 or go to the hospital of your choice. Only contact us in an emergency after you have already obtained emergency assistance from 911 or your choice of medical support.

Other after hour Mental Health Resources (not to be substituted for calling 911):

- Florida Suicide Prevention Coalition -FSPC (TALK) 24 hours a day; 7 days a week 1-800-273-8255
- David Lawrence Center, Naples Campus (24 Hour Walk-In Access) 239-455-8500
- Salus Care (24-hour assessments of adults and children) 239-275-3222
- Abuse Counseling & Treatment, Inc. (24-Hour Hotline) 239-939-3112 or Emergency Shelter 239-939-3112

Fees for Services Agreement

All clients must fill out this form in its entirety prior to receiving services.
Please note, your entire record including this form is stored on HIPAA compliant electronic server.

Please initial below:

____ Every time I schedule an appointment with my therapist I understand that I am entering into a contract with Sunshine State Counseling Center, LLC and for the professional time and services of my therapist.

____ I recognize that professional services include time and services for preparation for my scheduled session, the actual time in session, time spent outside of session with case review, case notes, confidential consultations with supervisors or professional colleagues as outlined above.

____ I understand my therapist's professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions.

____ I understand I have a right to request information about reduced fee options at any time.

____ I understand that Sunshine State Counseling Center, LLC has a cancellation policy requiring no less than 24 hours advance notice in order to be released from the contract for my therapist's time and services of preparation for my session.

____ I understand and agree that if I fail to cancel my appointment inside of the 24 hour minimum time period prior to my session I will be charged a $99 fee for the appointment.

☐ I hereby authorize Sunshine State Counseling Center, LLC to charge my Credit Card.

☐ I do not authorize Sunshine State Counseling Center, LLC to charge my Credit Card.

____ I understand if payment is not made before or during my scheduled session I am hereby authorizing Sunshine State Counseling Center, LLC to charge my afore-listed credit card for services rendered.

____ I understand this agreement authorizes Sunshine State Counseling Center, LLC to charge my credit card for services requested and rendered outside of the office such as email counseling, phone sessions, preparation of documents requested by me or any court related proceedings.

Name on card _____ ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Credit Card Number _____

Expiration date _____

Card security code _____

Billing address _____ City _____ State _____ Zip _____

Privacy Protection Notice

This notice describes how your mental health records may be used and disclosed and how you can get access to this information. Please read it carefully.

I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations. Treatment refers to activities in which we provide, coordinate or manage your mental health care or other services related to your mental health care.

Health care operations are activities related to the performance of our practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary." The use of your protected health information refers to activities the office conducts for filing your claims, scheduling appointments, keeping records and other tasks within the office related to your care. Disclosures refer to activities you authorize which occur outside the office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. We may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing us to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want us to send any of your protected health information of any sort to anyone outside the office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential.

III. Business Associates Disclosures

HIPAA requires that we train and monitor the conduct of those performing ancillary administrative service for the practice and refers to these people as "Business Associates." We do employ business associates to assist with administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., Florida Board of Clinical Social Work, Marriage & Family Therapy & Mental Health Counseling Department of Health)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s). We never release any information of any sort for marketing purposes.

V. Client's Rights and Sunshine State Counseling Center, LLC Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information, which we may or may not agree to, but if we do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so we will send them to another location of your choosing;
- The right to inspect and receive a copy of your protected health information in the designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- The right to amend material in your protected health information, although we may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- The right to an accounting of non-authorized disclosures of your protected health information;
- The right to a paper copy of notices/information from us, even if you have previously requested electronic transmission of notices/information; and
- The right to revoke your authorization of your protected health information except to the extent that action has already been taken. For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask us for further assistance on these matters. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and our duties regarding your PHI. We reserve the right to change our privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of our policies when you come for your future appointment(s). Our duties as mental health professionals on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and our privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of our internal policies for executing private practices, please let us know and we will get you a copy of these documents we keep on file for auditing purposes.

VI. Complaints

If you have any concerns of any sort that Sunshine State Counseling Center, LLC may have compromised your privacy rights, please do not hesitate to speak to us immediately about this matter. We are always willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

By law, We are required to secure your signature indicating you have received the Client Notification of Privacy Rights Document.

I, _____ , understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

I have read or had read to me all the information in this Information for New Clients. I have had a chance to review and ask questions and have had all questions answered to my satisfaction prior. I agree to abide by all the policies outlined herein including my full agreement to have Sunshine State Counseling Center, LLC Services. By signing this agreement, I am consenting to treatment; understand all the benefits and risks of counseling as outlined herein. I also hereby acknowledge that I have received and reviewed the HIPAA Privacy Policy notice form mentioned herein.

Client Signature or Parent if Minor/ Legal Guardian/Conservator or Authorized Representative, if Required — Date

Parent if Minor/ Legal Guardian/Conservator or Authorized Representative, if Required — Date

Signature of Sunshine State Counseling Center, LLC staff member — Date

☐ Client refused to acknowledge receipt.

Sunshine State
COUNSELING CENTER

Permission to Obtain/Release Confidential Information

Name of Client: _____ Date of Birth: _____

I hereby give consent to Sunshine State Counseling Center, LLC to exchange pertinent and relevant information with the Primary Care Physician identified below.

Name: _____ Agency: _____

Phone: _____ Fax: _____

Address: Street _____ City _____ State _____ Zip _____

Information obtained may include (check all that apply):

- ☐ Clinical Impressions and Records
- ☐ Academic Records (cumulative records, report cards, standardized test scores, etc.)
- ☐ Health Records
- ☐ Special Education Records/504 Plan Records (IEP, 504 Plans, PPT/Student Study Team minutes, evaluations)
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Social Work Evaluations
- ☐ Educational Evaluations
- ☐ Speech and Language Evaluations
- ☐ Other Evaluations (vocational, occupational, etc.)
- ☐ Other

_____

Client/Parent/Guardian Signature

_____

Print Name Relationship to Client Date

Sunshine State
COUNSELING CENTER

Important –Please complete and sign below if you would like this office to file insurance for you as a courtesy

Insurance Information for In-Office Outpatient Mental Health Services

Name of Insured _____

Insured's Birthdate _____

Social Security Number _____

Name of Employer _____

Address of Employer _____

_____

Insurance Company _____

Group _____

ID# _____

Insurance Company Address _____

_____

Insurance Company Phone # _____

How much is your deductible? _____

How much have you used this year? _____

Authorization and Release

____ I authorize the release of information including but not limited to: diagnosis and the records of any treatment rendered during the period of such care to third party payers and or health practitioners.

____ I authorize and request my insurance company to pay directly to _____

____ I understand that my insurance carrier may pay less than the actual bill for my services. I agree to be responsible for all services rendered on my or my dependent's behalf.

____ I authorize Sunshine State Counseling Center, LLC to charge my credit card for all services not covered by my insurance carrier.

Signature of Parent or Legal Guardian _____ Date: _____

Signature of Sunshine State Counseling Center, LLC Staff Member _____ Date: _____

Sunshine State
COUNSELING CENTER

Please complete the following brief assessments for children 11 and older. Your therapist will score each assessment and discuss the results with you.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid, as if something awful might happen	☐	☐	☐	☐

For office coding: _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ Male ☐ Female **Date:** _____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

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Illness Policy

At Sunshine State Counseling Center, we are doing our part to provide an environment that is healthy for our staff and clients. Our facilities are cleaned and sanitized on a regular basis. When your therapist is affected by a contagious illness, she will contact you by phone to cancel your appointment or switch to Telehealth, if possible. When you (or your child if he/she is the client) is feeling sick, we ask that you use the following guidelines to either cancel or switch to Telehealth appointment:

Illness	**Cancel/Telehealth**
Fever	Until fever-free for 24 hours.
Covid-19 Illness	When client has been in close contact with someone who has tested positive, tests positive, or shows symptoms of Covid-19. Client must be asymptomatic for 5 calendar days before returning to in-person treatment.
Other Respiratory Illness or vomiting	Until symptom-free for 24 hours
Strep Throat	Until client has been on antibiotic treatment for 24 hours and is fever-free for 24 hours.
Ringworm, Chicken Pox, Impetigo, & Pinkeye	Until symptoms have cleared up or note from medical professional determines that the condition is no longer contagious.

**If onset of illness happens within 24 hours of appointment, please be sure to contact the office and/or your therapist as soon as possible.*

PATIENT LATE CANCELLATION AND NO SHOW POLICY

At Sunshine State Counseling Center, we value our clients time and commitment to treatment, therefore we reserve for you a full hour of our time for your session and clinical notes. On occasions when it is necessary for you to cancel an appointment, a notice of 24 business hours (1 business day) is required prior to your scheduled appointment day and time or a $50 no-show fee will be charged to your credit card on file. A cancelled appointment delays our work and we are rarely able to fill a cancelled session unless our office is notified at least 24 hours in advance. If you are unable to make it to the office due to illness or other circumstances, you can call the office and request your appointment be switched to a Telehealth appointment so that you do not miss your appointment.

Sunshine State Counseling Center Late Cancellation and No Show* Policy:

- After each missed (late cancellation or no show) scheduled appointment the patient will be charged a $99.00 fee.
- No Show fees are due the day of the missed appointment, will be charged to card on file, and must be paid PRIOR to scheduling any future appointments.
- Clients who utilize Sunshine Health or Aetna Better Health of Florida insurance will not be charged a no-show fee.
- After 3 missed appointments, with or without excuse, we reserve the right to enforce a 60-day break in service. Appointment times following this break cannot be guaranteed and continued missed appointments following this 60-day break may result in additional breaks in service and/or the patient being discharged from our center.

It is the responsibility of the patient (or parent/guardian if patient is a minor) to notify Sunshine State Counseling Center of a cancellation by phone call or email at least 24 hours (1 day) in advance of the scheduled appointment or the $99 fee will be charged to the credit card on file. Leaving a voicemail message does not qualify as proper notification. Please follow up with an email to your therapist or administration to info@sscc.center

I have read and understand the Sunshine State Counseling Center patient cancellation and no show policy.

Patient Name (PRINT)	**For Minor Patients: Parent Name (Print)**
Patient or Parent Signature (Sign)	**Date**

Telehealth Policy

Sunshine State Counseling Center is dedicated to ensuring that you receive the best possible care with minimal interruptions. At times when you are unable to come to the office for therapeutic services, our therapists are able to offer you services via Telehealth. To participate in Telehealth therapy, you will need a secure internet connection and a computer or tablet with a video camera and microphone. Telehealth sessions can only be provided for clients located in the state of Florida.

SETTING UP FOR TELEHEALTH SESSION

Sunshine State Counseling Center utilizes Google Meet through a secure, HIPAA compliant account to provide Telehealth sessions. After your appointment has been scheduled, your therapist will email you a link that you will use to enter the private virtual meeting room for your session. Please log into your session a few minutes prior to the start time of your session to ensure that your connection is working. Be sure that your video and microphone are both on and ensure your therapist is able to see and hear you clearly. It is best for you to be sitting in a well-lit room with your face illuminated with the camera positioned so that your face is clearly visible to your therapist. It is important to be fully present during your session. In other words, this is not the time to be driving or completing other tasks. Therapy is an opportunity for great growth, insight, and improvement, and it deserves your complete attention, therefore you will want to be mindful of avoiding distractions.

PRIVACY

Sunshine State Counseling Center values your confidentiality. To ensure your privacy in Telehealth services, your therapist will connect with you from a space where she can reasonably ensure confidentiality and lack of interruption. Your therapist may use headphones and/or sound machines to enhance your privacy.

To ensure your confidentiality, we ask that you also set up a private space where others will not be able to hear your conversation. Using headphones/earbuds with a microphone may help minimize what other people nearby can hear. We recommend that you inform your therapist either in advance or at the beginning of each session if someone else is in the room or will be participating in the session. Your therapist has the right to exercise her clinical judgement to determine if the session should continue.

To ensure the productivity of the session, please do your best to avoid interruptions. We suggest meeting privately in a room with a closed door. It is ideal to leave pets and other household members out of this space during the session. Only use a secure

internet connection during your session. Using public Wi-Fi may mean that other people can access information during your session.

Please *do not* record sessions without your therapist's consent. Making recordings can quickly and easily compromise your privacy. In particular, please be mindful of how a recording meant for you alone can end up in the wrong hands. The risk is always there, in spite of your best efforts at keeping something secure. Further, please be aware that ***recording sessions without your therapist's knowledge and permission is a violation of Florida law.*** Within Florida, you may be sued if you record without consent.

TELEHEALTH FOR CHILDREN

We ask that children who are old enough to do so be allowed to attend their therapy session alone in a secure location. When discussed and agreed upon with the therapist prior to the session, one or more parents may be included in the session. Unless the session is a family session, we ask that all siblings be otherwise occupied in another room. It is important for the child client to feel his/her Telehealth session is safe and confidential, just as it would be in the therapy room at our office.

TROUBLESHOOTING/BACK-UP PLAN

- Therapist is unable to hear or see you?
    - Check that you have unmuted your microphone and enabled video capabilities.
- You cannot connect via the link sent?
    - Ensure you are connected to the internet and have adequate bandwidth.
    - Double check the link sent and try again. Call our office if you are still unable to connect.
- At times, internet can be unreliable due to storms and other outages. If you are experiencing this difficulty, please contact our office at 239-495-7722 as soon as possible. If your therapist is experiencing difficulty connecting to the internet, she will contact you by phone to let you know and set up an alternative meeting.

I have read and understand the Sunshine State Counseling Center Telehealth policy.

Patient Name (PRINT)	**For Minor Patients: Parent Name (Print)**
Patient or Parent Signature (Sign)	**Date**