Psychological Health Services

P-614-430-9697 F-614-430-9837 8472 Cotter Street Lewis, OH 43035

All paperwork is to be mailed 8472 Cotter Street Lewis Center, OH 43035 or emailed back or even dropped off between 9am and 4pm, paperwork can be faxed as well to: Fax# 614-430-9837.

Questionnaires are front and back be sure to do both sides!

Email paper work to:
Psychologicalhealthservices@gmail.com
Unfortunately, we can NOT schedule you until all your paperwork is returned to our office.

Your appointment will be over the phone **unless otherwise specified.**

We use a program called Google chat **if specified to use it when scheduled.**

Any questions or concerns please call our office at 614-430-9697.

Psychological Health Services

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Main Phone:( )_____ Other Phone: ( )_____

Insurance: _____ Insurance ID#_____

Additional Insurance_____ Policy#_____

Patient's Social Security#: _____ Age: _____

Patient's Gender: _____Male _____Female _____Other
Marital Status: _____ Single _____Married _____Other

If married, # of years married: _____ # of previous marriages: _____

E-mail Address: _____

Education (Highest grade/degree obtained): _____

Religion: _____

Occupation: _____

Patient's Employer: _____

Spouse's Name: _____DOB:_____

Spouse's Employer: _____

List all medications that the patient is taking:_____
_____
_____
_____

In case of emergency, call: _____ at phone#: _____

Referred by: _____

Where did you hear about us?_____
_____

SELF-EVALUATION QUESTIONNAIRE STAI Form Y-1

Please provide the following information:

Name_____ Date_____ S_____

Age_____ Gender (*Circle*) **M** **F** T_____

DIRECTIONS:

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel *right* now, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm	1	2	3	4
2. I feel secure	1	2	3	4
3. I am tense	1	2	3	4
4. I feel strained	1	2	3	4
5. I feel at ease	1	2	3	4
6. I feel upset	1	2	3	4
7. I am presently worrying over possible misfortunes	1	2	3	4
8. I feel satisfied	1	2	3	4
9. I feel frightened	1	2	3	4
10. I feel comfortable	1	2	3	4
11. I feel self-confident	1	2	3	4
12. I feel nervous	1	2	3	4
13. I am jittery	1	2	3	4
14. I feel indecisive	1	2	3	4
15. I am relaxed	1	2	3	4
16. I feel content	1	2	3	4
17. I am worried	1	2	3	4
18. I feel confused	1	2	3	4
19. I feel steady	1	2	3	4
20. I feel pleasant	1	2	3	4

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SELF-EVALUATION QUESTIONNAIRE

STAI Form Y-2

Name_____ Date_____

DIRECTIONS

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	ALMOST NEVER	SOMETIMES	OFTEN	ALMOST ALWAYS
21. I feel pleasant	1	2	3	4
22. I feel nervous and restless	1	2	3	4
23. I feel satisfied with myself	1	2	3	4
24. I wish I could be as happy as others seem to be	1	2	3	4
25. I feel like a failure	1	2	3	4
26. I feel rested	1	2	3	4
27. I am "calm, cool, and collected"	1	2	3	4
28. I feel that difficulties are piling up so that I cannot overcome them	1	2	3	4
29. I worry too much over something that really doesn't matter	1	2	3	4
30. I am happy	1	2	3	4
31. I have disturbing thoughts	1	2	3	4
32. I lack self-confidence	1	2	3	4
33. I feel secure	1	2	3	4
34. I make decisions easily	1	2	3	4
35. I feel inadequate	1	2	3	4
36. I am content	1	2	3	4
37. Some unimportant thought runs through my mind and bothers me	1	2	3	4
38. I take disappointments so keenly that I can't put them out of my mind	1	2	3	4
39. I am a steady person	1	2	3	4
40. I get in a state of tension or turmoil as I think over my recent concerns and interests	1	2	3	4

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BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry any more than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

PEARSON

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11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

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SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

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0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

*Obtain payment from designated third-party payers.

*Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Print Patient's Name_____Date_____

Patient's Signature (Parent's if minor)_____Date_____

Psychological Health Services

Informed Consent Form

INFORMATION DISCLOSURE STATEMENT

This is an informed consent form to be signed by all patients seen at Psychological Health Services. By signing this form you are acknowledging you understand and agree to the service explained below that you are having completed in our office.

Types of evaluations/Tests:

Neuropsychological Testing - $2,500.00 if **not** using insurance.

Psychological Testing for **anxiety or depression**- $350.00 if **not** using insurance.

Psychological evaluation for **opioid appropriateness**- $150.00 is **not** using insurance.

Psychological evaluation for **spinal cord stimulator**- $150.00 if **not** using insurance.

Psychological evaluation for **pain pump implant**- $150.00 if **not** using insurance.

Psychological evaluation for **bariatric procedure**- $500.00 if **not** using insurance.

Psychological Evaluations: The psychological evaluation is to assess appropriateness for various surgical procedures (e.g. spinal cord stimulator implantation, pain pump implantation, bariatric surgical procedures, etc.) Assessing potential risk factors of opiate/narcotic treatment of patients struggling with chronic pain.

Neuropsychological TESTING: Through the use of a variety of standard psychological tests, we will attempt to answer the questions that have brought you for this assessment. These questions generally concern learning disabilities, academic functioning, personality functioning, or coping styles. Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations.

The assessment process generally involves an informational interview followed by the administration of one or more educational and/or psychological tests. Although it is sometimes possible to complete the testing procedure in one sitting, it is common for people to be asked to return for another session to finish the assessment battery. Once testing is completed, the data will be analyzed and a report will be written. You will then have the opportunity to meet with your clinician to discuss the results and receive a copy of the report.

Confidentiality: You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality. Any information you wish to be shared with an outside party excluding payers, shall not be shared without a signed release form.

Client Consent

I as a patient of Psychological Health Services understand and agree to the services I will receive here. I understand my visit here is not a determination of my future treatment but an accurate assessment based on my responses to the evaluations I completed honestly and accurately. I understand any future decisions by the referred office or doctor is based solely on my responses to the evaluations I answered and Psychological Health Services is not responsible for their decisions.

Patient or guardian

Print name: _____ Date_____

Signature: _____ Date_____

PSYCHOLOGICAL HEALTH SERVICES

TELEPSYCHOLOGY INFORMED CONSENT

As a client receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.

2. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.

3. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

4. My psychologist may utilize alternative means of communication in the following circumstances: If internet goes out we will contact by phone.

5. My psychologist will respond to communications and routine messages within: ZOOM or Duo

6. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

7. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

_____
Client Printed Name

_____ _____
Signature of Client or Legal Guardian Date

_____
Printed Name of Psychologist

_____ _____
Signature of Psychologist Date

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to (Psychological Health Services) on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize (Psychological Health Services) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (Psychological Health Services). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Printed name of Patient, Authorized Representative or Responsible Party Date

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Relationship to Patient