



No Shows, Cancellations, & Payment for Services

Client Name: _____

When you schedule an appointment with our staff, West Texas Counseling & Guidance reserves that time just for you. If you are not going to attend your scheduled appointment, we would like to give another client the opportunity to take that opening. It affects our funding, our ability to budget our staff, and staff salaries when there are missed appointments. That is why we require **24-hour advance notification of cancellation**. Leaving a message with our answering service is fine, even on weekends. The time you called will be posted with the message. If you do not give 24 hours' notice before cancelling your appointment, do not show for your appointment, and/or are more than 15 minutes late more than two times in a three-month period, you may be asked to schedule with another therapist or moved to the WTCG wait list for services. Clients may also be charged a **\$50 missed fee** prior to being seen again. If you are being seen for reduced fee and pay less than \$50 per session, the fee will be your usual session charge. Those seen without a session fee will be charged \$5 per missed session.

Clients with certain insurances cannot be billed the missed appointment fee - Medicaid, Employee Assistance Programs (EAP), or some private insurances. We appreciate the courtesy you extend to us by honoring this agreement. Please note that **we cannot bill your insurance company for missed sessions** or for late cancellations. All clients scheduled to be seen in the appointment must be present in order for the appointment to be considered kept (both partners for couples counseling, etc.)

Certain insurances may not reimburse for some services offered at WTCG; in the event that insurance does not reimburse for a service provided and the client does not qualify for one of several client assistance programs at WTCG, the client will be held responsible for payment for that service.

Counselor Discretion: The counselor may choose to continue to see the client without requiring same- day appointments. The counselor may also waive the \$50 fee.

Weather Related: Missed appointments due to dangerous weather will not count as a late cancellation. Due to the counselors maintaining a set schedule:

- If you are 15 minutes late for 60-minute appointment, you may not be seen.
- If you are 10 minutes late for a 45-minute appointment, you may not be seen.
- If you are 5 minutes late for a 30-minute appointment, you may not be seen.

Court appearance: In the event disclosure of your records or the therapist's testimony are requested by you or required by law, you will be responsible for the costs involved in producing the records and the therapist's normal **hourly rate of \$104.00** for giving that testimony. If a clinician is required to travel to a court location out of town, per diem and mileage are additional costs that you will be responsible for. Such payments are to be made prior to the time the services are rendered by the therapist.

By signing this agreement, I acknowledge my understanding of all the policies listed above. I accept and agree to all of the above terms during the course of my treatment at West Texas Counseling & Guidance.

Signature of Client/Guardian or Parent if client is a minor

Date

Signature of WTCG Staff

Date

Patient Health Questionnaire- 9 (PHQ-9)

Client Name: _____

Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Circle your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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=Total Score: _____

If you circled 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

General Anxiety Disorder (GAD-7)

NAME _____

DATE _____

	Not at all sure	Several days	Over half the days	Nearly every day
1. Over the last 2 weeks, how often have you been bothered by the following problems?				
• Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Being so restless that it's hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Becoming easily annoyed or Irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<i>Add the score for each column</i>				
TOTAL SCORE <i>(add your column scores)</i>				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, 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?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence.

I have not experienced a traumatic event as described and/or decline to complete the following forms.

PCL-5
Weekly Version During Treatment

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

The event you experienced was _____ on _____.
(event) (date)

<i>In the past week, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Scoring for use by study personnel only:

ADD COLUMNS:

+	+	+
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TOTAL:

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Columbia-Suicide Severity Rating Scale

SUICIDE IDEATION DEFINITIONS AND PROMPTS		Since Last Visit	
Ask questions that are bolded and <u>underlined</u> .		YES	NO
Ask Questions 1 and 2			
1	Wish to be Dead: <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u> Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.		
2	Suicidal Thoughts: <u>Have you actually had any thoughts of killing yourself?</u> General non-specific thoughts of wanting to end one's life/commit suicide, " <i>I've thought about killing myself</i> " without general thoughts of ways to kill oneself/associated methods, intent, or plan.		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.			
3	Suicidal Thoughts with Method (without Specific Plan or Intent to Act): <u>Have you been thinking about how you might kill yourself?</u> Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. <i>"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."</i>		
4	Suicidal Intent (without Specific Plan): <u>Have you had these thoughts and had some intention of acting on them?</u> Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to " <i>I have the thoughts but I definitely will not do anything about them.</i> "		
5	Suicide Intent with Specific Plan: <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u> Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.		
6	Suicide Behavior Question: <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
Total:			