ADVANCED PAIN CARE

INFORMATION, CONSENT AND AGREEMENT FOR TELE-THERAPY SERVICES

Name: _____ **Date of Birth:** _____

TELE-THERAPY EXPECTATIONS:

I understand that, in general, the goal of counseling is to help me learn to cope independently with my chronic pain and the demands of life and that, depending on the needs of the individual, the length of counseling varies. I am aware certain effects are possible when engaging in the counseling process—such as increased stress, emotional discomfort and the disruption of current interpersonal and family relationships. I have the right to terminate counseling at any time for any reason, and understand that referrals to other providers will be provided by the therapist upon request. **It is strongly recommended that any decision to terminate counseling or to switch to another provider be discussed with the therapist.** I hereby consent to engage in tele-therapy services. I understand that tele-therapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that tele-therapy also involves the communication of my medical/mental information, both orally and visually. I understand that I have the following rights with respect to tele-therapy: The laws that protect the confidentiality of my medical information also tele-therapy, including, but not limited to, the possibility, that the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons despite using software that is hippa compliant. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services.

THERAPEUTIC RELATIONSHIP:

The relationship between therapist and client is the container through which client change can take place. As such, it is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. For the most part, the therapeutic relationship begins and ends at the therapy office. Although this is sometimes difficult to understand, it is a necessary requirement for maintenance of the therapeutic environment. As such, your therapist cannot be expected to be involved in a social relationship or friendship of any kind that exists outside of the therapy room.

THERAPIST ORIENTATION AND CREDENTIALS:

There are many different approaches to the therapeutic process. Your therapist will work with you to provide you with the most appropriate interventions for your particular issue(s) and goals. Our therapists use a variety of therapeutic modalities, including but not excluding, EMDR, hypnosis, ACT, and CBT. Please discuss any concerns you have regarding your treatment with your therapist at any time during the process. All of the therapists go through a rigorous screening process. We are committed to selecting the most qualified therapists.

CLIENT RESPONSIBILITY:

I understand that my counseling session is reserved exclusively for me, and this Agreement represents a commitment on my part to take an active role in my therapy. Therefore, I agree to the following:

- **Appointments** ○ Each therapy session will be **20-60** minutes in length. Different appointment types will be discussed with you.
- **Fee/Payment** ○ Payment is sue at the time of service
    - If payment cannot be made for the current appointment, arrangements must be made for payment to occur by the end of the following appointment.
    - If payment for the current appointment is not made by the end of the day of the following appointment, sessions may be suspended until payment is made.
    - If more than one session has been without, termination or suspension if services may result.

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- **Punctuality** ○ I will arrive promptly at the scheduled time. ○ In the event I know I will be late for an appointment, I will notify APC's Behavioral Health Services. ○ If I am late for an appointment, I agree that the session will end at the regularly scheduled time.
    - If the therapist is late, I will be provided the full session.
- **Missed Appointments** ○ If I am unable to keep a schedule appointment, I will notify APC's Behavioral Health Services **24 hours** in advance (512.244.4272)

CONFIDENTIALITY: APC is a multidisciplinary practice. BH providers have full access to your medical records, and the medical staff has full access to the BH records. The therapist will follow all applicable laws, rules, regulations, guidelines and codes of ethics and conduct concerning your privacy relating to the therapist and the client/therapist relationship in connection with counseling sessions and records. You should be aware, however, that there are exceptions to your expectation of privacy with regard to the counseling sessions and records of those sessions with the therapist. Those exceptions include certain situations where the therapist may be obligated to disclose such information, including instances:

- Involving abuse or neglect of minors or risk to minors
- Involving abuse, neglect, or exploration of elderly or disabled persons
- Involving abuse, neglect, or illegal, unprofessional, or unethical conduct in an inpatient mental health facility, a chemical dependency treatment facility, or hospital providing comprehensive medical rehabilitation services • Involving sexual exploration by mental health services provider or clergy person
- Involving abuse or neglect in nursing facility
- When the client presents a danger to self or others
- Involving certain audits of APC Behavioral Health Services or its program
- Involving a therapist's or other mental health services provider's improper conduct

Worker's Compensation **–** If there is a worker compensation claim, your insurance has access to your records relating to your diagnosis and treatment of the work related injury.

There may be other situations when APC's Behavioral Health Services or therapist may disclose such information without a court order, subpoena or your consent. By signing below, you acknowledge that you understand that your expectation of privacy is limited and that client/therapist communications and therapist records may be disclosed to third parties. You also agree that information regarding billing may be shared with a third party (such as insurance billing administrators and bill collectors) and that your case may be discussed with a program supervisor or treatments team, including the referring and/or treating physician. APC's Behavioral Health Services uses a team approach to therapy and information is shared among staff therapist and the supervisor as appropriate to ensure professional quality. However, confidentiality standards are observed by the entire APC's Behavioral Health Services staff.

AFTER HOURS PROCEDURES

If you need to contact your therapist outside of the therapy session, you may do so by leaving a message for him or her through the APC main number. At 512.244.4272. IF YOU ARE IN A CRISIS, PLEASE CALL THE 24-HOUR HOTLINE AT 512.472.HELP or 911. We are not a crisis facility.

ADVANCED PAIN CARE

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GRIEVANCE PROCEDURE OR COMPLAINTS AGAINST A THERAPIST:

The therapist will provide services in a professional manner consistent with all applicable laws, rules, regulations, guidelines and codes of ethics and conduct concerning the therapist and the client/therapist relationship. Any dissatisfaction with services or other complaint should be discussed with the therapist or the therapist supervisor. If you do not believe, your complaint was handled in a satisfactory manner, please contact:

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3183
(512) 834-6658

Texas State Board of Social Worker Examiner
1100 West 49th Street
Austin, Texas 78756-3183
(512) 719-3521

The relationship between the therapist and the client is considered a professional one. The therapist's professional code of ethics prohibits any other relationship between the therapist and the client, including any non-counseling activity initiated by either the therapist or the client for the purpose of establishing a non-therapeutic relationship, such as social contact.

AGREEMENT:

By signing below, I acknowledge that I have read, understood and agree to everything in this Agreement, and authorize payment to APC's Behavioral Health Services. I also authorize APC's Behavioral Health Services to release any information necessary to process my insurance claims or other billing to their agents.

_____ _____

Client Signature Date

_____ _____

Client Name Date

ADVANCED PAIN CARE

Patient Name: _____ **DOB:** _____ **Date:** _____

CSQ

Individuals who experience pain have developed a number of ways to cope or deal with the pain. These include saying things to themselves when they experience pain or engaging in different activities. Below is a list of things that patients have reported doing when they feel pain. For each activity, I want you to indicate using the scale below, how much you engage in that activity when you are in pain. A 0 indicates that you never do that when you are experiencing pain and a 3 indicates that you sometimes do that when you are experiencing pain and a 6 indicates that you always do it when you are experiencing pain. Remember, you can use any point along the scale.

0 1 2 3 4 5 6

Sometimes do that — Always do that — Never do that

When I feel pain …

____ 1. I try to feel distant from the pain, almost as if the pain was in somebody else's body.

____ 2. I leave the house and do something, such as going to the movies or shopping.

____ 3. I try to think of something pleasant.

____ 4. I do not think of it as pain, but rather as a dull or warm feeling.

____ 5. It is terrible and I feel it is never going to get any better.

____ 6. I tell myself to be brave and carry on despite the pain.

____ 7. I read.

____ 8. I tell myself that I can overcome the pain.

____ 9. I count numbers in my head or run a song through my mind.

____ 10. I just think of it as some other sensation, such as numbness.

____ 11. It is awful and I feel that it overwhelms me.

____ 12. I play mental games with myself to keep my mind off the pain.

____ 13. I feel my life is not worth living.

____ 14. I know someday someone will be here to help me and it will go away for a while.

____ 15. I pray to God it will not last long.

____ 16. I try not to think of it as my body, but rather as something separate from me.

____ 17. I do not think about the pain.

____ 18. I try to think years ahead, what everything will be like after I have gotten rid of the pain.

____ 19. I tell myself it does not hurt.

____ 20. I tell myself I cannot let the pain stand in the way of what I have to do.

____ 21. I do not pay any attention to it.

ADVANCED PAIN CARE

Patient Name: _____ **DOB:** _____ **Date:** _____

0 1 2 3 4 5 6

Sometimes do that Always do that Never do that

When I feel pain …

____ 22. I have faith in doctors that someday there will be a cure for my pain.

____ 23. No matter how bad it gets, I know I can handle it.

____ 24. I pretend it is not there.

____ 25. I worry all the time about whether it will end.

____ 26. I replay in my mind pleasant experiences in the past.

____ 27. I think of people I enjoy doing things with.

____ 28. I pray for the pain to stop.

____ 29. I imagine that the pain is outside of my body.

____ 30. I just go on as if nothing happened.

____ 31. I see it all as a challenge and do not let it bother me.

____ 32. Although it hurts, I just keep on going.

____ 33. I feel I cannot stand it anymore.

____ 34. I try to be around other people.

____ 35. I ignore it.

____ 36. I rely on my faith in God.

____ 37. I feel like I cannot go on.

____ 38. I think of things I enjoy doing.

____ 39. I do anything to get my mind off the pain.

____ 40. I do something I enjoy, such as watching TV or listening to music.

____ 41. I pretend it is not a part of me.

____ 42. I do something active, like household chores or projects.

ADVANCED PAIN CARE

Patient Name: _____ **DOB:** _____ **Date:** _____

PAIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by 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	☐ 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 tires 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

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

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

For office coding: _____ **+** _____ **+** _____ **+** _____ ***Total Score:*** _____

ADVANCED PAIN CARE

Patient Name: _____ **DOB:** _____ **Date:** _____

GAD- 7

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

(Use "✔" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it is hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3

For office coding: Total Score T____ = ____ + ____ + ____

Patient Name: _____

DOB: _____ **Date:** _____

If an informant completes this questionnaire, **what is your relationship with the individual?** _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

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

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Patient Name: _____ **DOB:** _____ **Date:** _____

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**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. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	