

APPENDIX D – INFORMED CONSENT



Consent:

Your signatures and initials below indicate that you consent to enter therapy through an informed decision. This document will serve as the contract between the client and the Olson Clinic. This document outlines clinic procedures, client/Student Therapist relationships and serves as a guideline for our working relationship.

The Gerald & Audrey Olson Marriage & Family Therapy Clinic (Olson Clinic) is a teaching-clinic, and therapy is conducted by students under the supervision of Licensed Marriage and Family Therapists and AAMFT-approved Supervisors/Supervisor candidates. In order to provide the best services possible, sessions are subject to video recording or observation by clinic Supervisors or other students in the Olson Clinic. Supervisor/Clinical Director may deem it important or necessary to be part of/join/conduct sessions at the Olson Clinic. All Student Therapists and faculty Supervisors are required to uphold the Code of Ethics of the American Association of Marriage and Family Therapists and Iowa Law. Copies of these codes are available upon request.

The Olson Clinic cannot make recommendations on or conduct evaluations for custody of children. The Olson Clinic cannot provide primary treatment for active substance use and abuse. The Olson Clinic cannot see clients that are experiencing active psychosis.

I understand therapy sessions are video and audio recorded for review at the Olson Clinic, and in signing this informed consent, I agree to allow The Olson Clinic to record my sessions.

I understand that The Olson Clinic is not a crisis center and is not staffed or qualified as one. I agree that if I am in crisis or assessed to be in crisis, the clinic staff and/or Student Therapist will refer me to or call crisis management on my behalf, which could include 911, police and/or mobile crisis.

I agree to enter the therapy process aware that there may be potential for emotional strains, stresses, and life changes as a result of therapy. I agree that The Olson Clinic does not guarantee any particular results or outcome from the therapy process.

When I do decide to terminate therapy, I agree to discuss this decision in a regular session with my therapist. Due to the nature of this clinic, if a file goes 30 days with no activity, it will be closed. I am still responsible for all unpaid fees at the time of closure. In the event that I wish to attend therapy again in the future, the file may be reopened by calling (319-368-6493).

I understand that “The Good Faith Estimate” which is given to me during intake for my personal records includes personal health information. During the course of treatment, there may also be other documents provided to me by my therapist that include personal health information. When such document(s) are given to me, I understand that I am responsible for safeguarding their contents as I see fit. I will not hold the Olson Clinic and/or its staff members/providers liable for any information that may be seen by another party on forms and documents from the Olson Clinic that are in my possession.

You will provide your initials on each page of the Informed Consent to indicate your understanding of their contents. Each adult who is present for the session—not just the client on file—should provide their initials. Thus, up to 6 spots for initials are provided in the case of large therapy groups.

Initials _____

Cancellations and Associated Fees:

24-hour notice is required for all cancellations. If appropriate notice is not given, 50% of your session fee will be charged to your file. After three cancellations with less than 24-hours' notice, your file may be closed. In the case of a returned check, a \$25 fee will be added to the account.

HIPAA:

I acknowledge I have received, have read (or had read to me), and understand the contents of The Olson Clinic Notice of Private Practices. I fully understand its contents, and if I had any questions regarding this document, they have been fully answered.

Confidentiality:

All Student Therapists and faculty Supervisors are required to hold information about sessions and clients in confidence. The Olson Clinic will not disclose client information without the expressed written consent of every member involved in treatment. This means that if more than one person is involved in treatment, all individuals associated with that treatment must sign a release of information before any information will be provided for use outside the clinic. This applies to all session types: in-person, telehealth, or phone.

The exceptions to confidentiality policies are the following circumstances:

1. If there is clear and imminent danger to you or others, in which case either clinic may be required to inform the responsible authorities or warn the identified victim. In this event, the therapist will inform you of their responsibilities and actions.
2. In situations of suspected physical, emotional, or sexual abuse of a child, elderly or dependent adult abuse, therapists are required to submit a report to the Department of Human Services and may be required to contact authorities. Again, in this situation, you would be informed of the therapist's responsibilities and actions.
3. The clinic maintains records of treatment, diagnosis, assessment, and treatment planning in order to collaborate with Clinic Staff (Clinic Staff includes Student Therapists, Supervisors, Administrative Assistants, and Clinic Interns or Work Studies) to better inform your treatment and assess the effectiveness of treatment provided. You may request restrictions as to how your case information may be used or shared among clinic staff; however, the Olson Clinic is not required to agree to those restrictions.
4. As the Olson Clinic is a training facility, you agree that staff, clinical supervisors, and other therapists may have access to confidential information for the purpose of clinical effectiveness.
5. Some litigation may require the release of records even without the client's authorization. Student therapists will not typically testify in court (unless mandated) as this is outside of their scope of training, and they are not qualified to do so.

Research:

I am aware the Olson MFT Clinic uses all client paperwork and video/audio recordings for academic research purposes. **No identifying information is used for this research, including name, date of birth, address, etc.** Each client will be randomly assigned a number to ensure confidentiality further, and all paperwork and recordings will be kept in a safe and secure location within the clinic. When needed, video recordings will be coded for research purposes, but no raw footage will be used. If at any point, you would like to withdraw your information from the data that is being collected, you are able to do so by letting your therapist or the front office staff know. There are no known risks associated with the collection of this data.

Initials _____

SESSIONS

Sessions will be conducted in either in-person or telehealth/phone sessions. The session type will be determined by the client and Student Therapist. They will strive to honor your preferences so long as they are feasible and clinically appropriate. There may be some situations where your student therapist, or supervisor/clinical director, may require that you meet via telehealth only. If you have concerns about meeting through telehealth, they will discuss it with you and attempt to address your concerns.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect that decision as long as it is feasible and clinically appropriate.

Depending on session type, the client will adhere to the following guidelines:

IN-PERSON SESSIONS GUIDELINES RELATED TO THE CORONAVIRUS

MMU, and/or The Olson Clinic cannot guarantee that you, your partner, or your child(ren) will not become infected with COVID-19 as a result of entering MMU, and/or The Olson Clinic. Further, attending in-person sessions could increase your risk, your partner's risk, and your child(ren)'s risk of contracting COVID-19.

RISKS OF OPTING FOR IN-PERSON SERVICES

I acknowledge the contagious nature of COVID-19. I voluntarily assume the risk that myself, my partner, and my child(ren), and I may be exposed to or infected by COVID-19 by attending in-person sessions and that such exposure or infection may result in personal injury, illness, permanent disability, and death.

By initialing, you understand that MMU, and/or The Olson Clinic have zero control over whether or not those other individuals are taking action to minimize exposure or protect you from COVID 19, and you will not hold MMU, The Olson Clinic and/or the personally liable of actions/inactions other individuals have/have not taken to limit the spread of infection.

I understand that the risk of becoming exposed to or infected by COVID-19 at MMU, and/or The Olson Clinic may result from the actions, omissions, or negligence of myself and others, including, but not limited to, MMU, and/or The Olson Clinic staff/employees, faculty, volunteers, students, and other professionals are working in the building, practicum students, or other clients/persons who were in the building.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself, my partner, or my child(ren) (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I, my partner, or my child(ren) may experience or incur in connection with my, my partners, or child(ren)'s attendance at MMU, and The Olson Clinic ("Claims").

On my behalf, and on behalf of my partner, and child(ren), I hereby release, covenant not to sue, discharge, and hold harmless MMU, and The Olson Clinic, its students, faculty, staff/employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto.

Initials _____

I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of MMU, and The Olson Clinic, its students, faculty, staff/employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person therapy sessions. I understand and agree to take the risk of exposure to the Coronavirus.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

Wearing a Mask:

Consistent with University guidelines, you are not required to wear a mask during in-person sessions at the Olson Clinic. If your student therapist requests that masks be worn during session, we ask that you respect their wish. Likewise, if you request that masks be worn during session, our student therapist(s) will respect your entreaty.

Before a Session:

If you have a temperature over 100.4 degrees Farenheit or if you have other symptoms of the Coronavirus, you agree to cancel the appointment or proceed using telehealth. If you know you have been exposed to the Coronavirus, you will cancel your session or will move to telehealth. If you wish to cancel for these reasons, you will not be charged our normal cancellation fee.

TELEHEALTH GUIDELINES

Telemental-health involves the use of electronic communications to enable health care providers to share individual patient therapeutic information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient therapeutic records; Therapeutic images; Live two-way audio and video; Output data from therapeutic devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Using Email to Communicate with your Therapist

Due to the risk inherent in HIPAA compliance with the use of any telemental-health or technology devices, please consider the following considering using email to communicate with your Student Therapist or Clinic Staff:

“If individuals are notified of the risks and still prefer unencrypted email, **the individual has the right to receive protected health information in that way**, and covered entities are not responsible for unauthorized access of PHI while in transmission to the individual, based on the individual's request. Further, covered entities are not responsible for safeguarding information once delivered to the individual” (U.S. Department of Health and Human Services, 2013).

I understand & agree to each of the following statements regarding telehealth:

I understand the risks of receiving an email for my appointment through Zoom and/or KASA (medical records system) and I still prefer to receive these.

Initials _____

I understand the risks of receiving communicating with my therapist about appointment times via email and I still prefer to receive these.

If you are opting out of email communication with your Student Therapist and/or Clinic Staff, please indicate this here _____

I understand that all electronic communication is a part of my legal-medical record.

I understand that I have to be physically located in the State of Iowa at the time of my session. If I am in another state, I understand I must reschedule the session.

I understand I am not to be in the act of driving. If I am, I understand the session will be rescheduled.

I understand that in very rare instances, security protocols could fail, causing a breach of privacy of personal therapeutic information.

I also understand that the Olson MFT Clinic utilizes the below suicidality protocol while doing telehealth sessions:

- I understand I will be asked every session before starting the session if I have any suicidal thoughts, ideation, plan or intention.
- If my Student Therapist deems that I am a risk to myself, I will be required to call Foundation 2 crisis line (319-362-2174) so that I can be fully assessed for safety.
- I understand I cannot continue sessions without confirmation of safety.
- I understand if I tell my therapist I have intentions or plans to kill or hurt myself or others, my therapist will call mobile crisis, 911 and/or police.

By agreeing to Telehealth (video) session via HIPAA compliant Zoom, you agree to assume the risk of limited confidentiality of the session content and personal protected health information.

PHONE

Phone sessions are *not* HIPAA compliant due to the nature of phones. Your Student Therapist will do everything they can to maintain your confidentiality in a phone session but cannot promise confidentiality

By agreeing to sessions via phone, you agree to assume the risk of limited confidentiality of the session content and personal protected health information.

Initials _____

NON-RECORDING AGREEMENT

Successful therapy depends on building a relationship of trust, good faith, and openness between client(s) and therapist(s). Often, audio or video recording can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith to all the other persons in the room.

In addition, recordings made and taken home by clients sometimes fall into unintended hands through loss, random or targeted theft, or action by police, court or governmental agency. Such loss could compromise or nullify your legal expectation of confidentiality in the extremely sensitive personal or interpersonal matters that may have been discussed. Courts may not give your own recordings all the legal confidentiality they give to a therapist's office notes and may find them self-serving. Client recordings can more easily end up becoming an issue in conflicts such as divorce, child custody, or other legal cases or be used by agencies of government. A client who makes a recording solely for personal use or to use against a partner may later be surprised to find the recording being used against him- or herself instead. And once an unfavorable recording exists, its deletion can become legally punishable if a subpoena is issued for it. Additionally, most users of recording technology lack the technological tools and knowledge required to delete a recording in a way that makes it unrecoverable and unhackable.

Factors like these undermine the therapeutic process and the building or rebuilding of trust that takes place between partners in session and between the client(s) and therapist(s). For these reasons and others like them, the Olson Clinic maintains a strict policy on recording. Therapists at Olson Clinic will only consent to recording of a session for exceptional reasons and only after the drawbacks and risks have been discussed and the benefit clearly outweighs them.

Therefore, the client agrees that:

Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally, the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

Initials _____

FEES

Fees for Service [Student Therapist will fill out]: \$ _____ /session

In-person, telehealth or phone session fee are billed at the same rate. Fees are determined on a sliding fee scale below and are due at the time of the session.

Sliding Fee Schedule – Based on 2021 Federal Poverty Guidelines					
Family Size	Minimum	25% Pay	50% Pay	75% Pay	100% Pay
Income Level	100%	133%	166%	200%	233%+
1	\$12,880	\$17,130	\$21,381	\$25,760	\$30,010
2	\$17,420	\$23,169	\$28,917	\$34,840	\$40,589
3	\$21,960	\$29,207	\$36,454	\$43,920	\$51,167
4	\$26,500	\$35,245	\$43,990	\$53,000	\$61,745
5	\$31,040	\$41,283	\$51,526	\$62,080	\$72,323
6	\$35,580	\$47,321	\$59,063	\$71,160	\$82,901
7	\$40,120	\$53,360	\$66,599	\$80,240	\$93,480
8	\$44,600	\$59,318	\$74,036	\$89,200	\$103,918
Fee	\$10.00	\$15.00	\$20.00	\$25.00	\$30.00

CONSENT

By signing below, I agree to the guidelines outlined in regard to General Clinic Procedures, In-Person Sessions, Telehealth and Phone Guidelines. I agree to pay the fee assigned above. I agree that consent to services remains in effect as long as I attend the Gerald & Audrey Olson Marriage & Family Therapy Clinic and/or Mount Mercy University Counseling Center and can only be revoked by me in writing with such notice being provided to the clinic.

I have read this form and I AGREE to receive counseling services.

I have read this form and I DECLINE to receive counseling services.

_____ Date

Signature of Client Who’s Name is on File for this Session:

_____ Print Client Name/Legally Authorized Person

_____ Signature

_____ Relationship to Client

Signatures of Additional Client(s) Who are Joining For Therapy:

Print Client Name/Legally Authorized Person	Signature	Relationship to Client
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Contact Information: email: _____ phone: _____

Print Client Name/Legally Authorized Person	Signature	Relationship to Client
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Contact Information: email: _____ phone: _____

Print Client Name/Legally Authorized Person	Signature	Relationship to Client
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Contact Information: email: _____ phone: _____

Print Client Name/Legally Authorized Person	Signature	Relationship to Client
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Contact Information: email: _____ phone: _____

Print Client Name/Legally Authorized Person	Signature	Relationship to Client
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Contact Information: email: _____ phone: _____

APPENDIX G – RELEASE OF INFORMATION



I, _____, hereby authorize the Gerald and Audrey Olson Marriage and Family Therapy Clinic (hereinafter referred to as the Olson MFT Clinic) to release verbal and/or written information to:

Full name of person or entity Phone Fax

Address

For the following purposes:

- Treatment and assessment □ Coordination of care □ Referral of new or additional services

□ Other _____

Specific information to be released includes:

- Assessment and diagnosis □ Treatment goals □ Session Content □ Discharge

□ Other: _____

I understand that by signing this General Authorization I am authorizing the Olson MFT Clinic to disclose my health information to the persons and entities listed above and that any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to the Olson MFT Clinic.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to the Olson MFT Clinic. I understand that my revocation of this General Authorization will not affect a disclosure that the Olson MFT Clinic has already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Olson MFT Clinic’s confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

I understand that signing this is not a condition of receiving services.

This authorization will expire 12 months from the date it was signed or on the specified date of ___/___/___.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.
(INITIAL ANY CATEGORY NOT TO BE RELEASED)
_____ Mental Health _____ Substance Abuse _____ HIV/AIDS _____ Genetic information including genetic test results

Print Client Name/Legally Authorized Person Signature Date

Therapist Name Signature Date

APPENDIX H – DEMOGRAPHIC FORMS

ADULT



Name: _____

Age: _____

I identify my gender as: _____

My pronouns are: _____

I identify my race and/or ethnicity as: _____

My religious affiliation is (if any): _____

What is your highest level of education obtained?

- | | |
|--|---|
| <input type="checkbox"/> Elementary | <input type="checkbox"/> Some College |
| <input type="checkbox"/> Junior High | <input type="checkbox"/> College Degree |
| <input type="checkbox"/> Some High School | <input type="checkbox"/> Master's Degree |
| <input type="checkbox"/> High School Diploma | <input type="checkbox"/> Professional Degree (Ph.D., M.D., etc) |
| <input type="checkbox"/> Other: _____ | |

Number of individuals in my household is: _____.

My household income is: _____

On average, I work about _____ hours per week.

What is your relationship status?

- Single
- Married
- Separated
- Divorced
- Cohabiting/Live with
- Other _____

Please mark if applicable:

- I am a veteran / a family member of a veteran.
- I am a Mount Mercy University faculty, staff, student and/or a family member of a Mount Mercy University faculty or staff member
- I am a COVID first responder/family member

How did you hear about us?

APPENDIX I – BIOPSYCHOSOCIAL ASSESSMENTS

ADULT



Current Symptom Checklist

I AM FEELING...	Never	Rarely	Sometimes	Frequently	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement of Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about the future					
Excessive feelings of guilt					
Low self-esteem					
I AM EXPERIENCING...	Never	Rarely	Sometimes	Frequently	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
“Flashbacks” as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about a traumatic experience					
I NOTICE...	Never	Rarely	Sometimes	Frequently	For how long?
I am Angry, Irritable, Hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My mood fluctuates: go up and down					

I HAVE...	Never	Rarely	Sometimes	Frequently	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE...	Never	Rarely	Sometimes	Frequently	For how long?
Risk-taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

EMPLOYMENT & SELF CARE	Never	Rarely	Sometimes	Frequently	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

MY EATING INVOLVES...	Never	Rarely	Sometimes	Frequently	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss					
A lot of weight gain					

I HAVE...	Never	Rarely	Sometimes	Frequently	For how long?
Concern about my sexual function					
Discomfort engaging in my sexual activity					
Questions about my sexual orientation					

Psychiatric History

Prior outpatient psychotherapy? YES NO

Name	Provider	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior inpatient psychotherapy? YES NO

Name	Provider	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior and/or current medication use? YES NO

Medication	Dosage	Frequency	Start Date	End Date	Physician

Has any family member had mental or emotional problems that warrant treatment? YES NO
 If yes, who / what / why (list all):

Relationship and Family History

Relational status

- Single
- Married
- Separated/Divorced
- Cohabiting
- Other _____

Intimate relationship

- never been in a serious relationship
- not currently in relationship
- currently in a serious relationship

Relationship satisfaction

- very satisfied with relationship
- satisfied with relationship
- somewhat satisfied with relationship
- dissatisfied with relationship
- very dissatisfied with relationship

List family members

<u>Name</u>	<u>Age</u>	<u>Gender</u>	<u>Relationship to Client</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any past or current significant issues in intimate relationships or immediate family relationships:

MEDICAL HISTORY

Describe current physical health Good Fair Poor

Comments:

List any non-psychiatric medications and supplements currently being taken (give dosage and reason) Not applicable

List any known allergies Not applicable

Substance and Alcohol Use History

I USE THE FOLLOWING...	Never	Rarely	Sometimes	Frequently	For how long?
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

Client Treatment History

- Outpatient (age[s]) _____
- Inpatient (age[s]) _____
- 12-step program (age[s]) _____
- Stopped on own (age[s]) _____
- Other (age[s]) _____

Family alcohol/drug abuse history

- father stepparent/live-in
- mother uncle(s) and/or aunt(s)
- grandparent(s) /significant other
- Sibling(s) children
- other _____

Uses of Substance and/or Alcohol Use

- hangovers
- seizures
- blackouts
- Accidental overdose
- Binges
- Arrest(s)
- Withdrawal symptoms
- Medical Conditions
- Increase of Tolerance
- Loss of Control over amount used
- Job Loss
- Other _____
- Sleep disturbances
- Assault (s)
- Suicide Attempt(s)
- Suicide Impulse/Thoughts
- Sleep disturbances

Socio-Economic Status History

Living Situation

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional

Employment

- employed and satisfied
- employed but dissatisfied
- unemployed
- coworker conflicts
- Supervisor conflicts
- unstable work history
- disabled: _____

Social support system

- supportive network
- few friends
- substance-use-based friends
- no friends
- distant from family of origin

Financial situation

- no current financial problems
- large indebtedness
- poverty or below-poverty income
- impulsive spending
- relationship conflicts over finances

Legal history

- no legal problems
 - now on parole/probation
 - arrest(s) not substance-related
 - arrest(s) substance-related
 - court ordered this treatment
- jail/prison _____ time(s), total time served: _____

APPENDIX K – GOOD FAITH ESTIMATE



GOOD FAITH ESTIMATE

At The Gerald & Audrey Olson Marriage & Family Therapy Clinic (Olson Clinic) therapy is conducted by students under the supervision of Licensed Marriage and Family Therapists and AAMFT-approved supervisors/supervisor candidates.

Student Clinician Name: _____

<i>Supervisor Name</i>	<i>License Number</i>	<i>NPI Number</i>
Dr. Tabitha Webster	093094	1053618686
Dr. Heather Morgan-Sowada	000388	1427449503
Dr. Anthony Mielke	093697	1578082848
Dr. Douglas McPhee	110008	1023638673

Olson Clinic Phone: 319-368-6493
Olson Clinic Address: 1650 Matterhorn Dr. NE, Cedar Rapids, IA 52402
Tax ID: 420681046

Patient Name:	
Patient Address:	
Patient Phone #:	Patient Email:
Patient Diagnosis (if known/applicable):	
Services Requested:	

You are entitled to receive this “Good Faith Estimate” of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of

services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The fee for a 45-minute psychotherapy visit (in-person or via telehealth) is \$_____. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Based upon a fee of \$_____ per visit, if you attend one psychotherapy visit per week, your estimated charge would be \$_____ for four visits provided over the course of one month; \$_____ for eight visits over two months; or \$_____ for 12 visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means \$400 or more beyond the estimated charges).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate _____

APPENDIX L – SCREENERS

ADULT



Client Name: _____

Student Therapist Name: _____

Student Therapists must use this form to screen for any conditions that might rule out their adult client(s) from receiving services at the Olson MFT Clinic. Student therapists must complete this form during the course of the intake procedure and upload a copy to the client's file. If working with a couple, a screener for each client should be uploaded.

Clients who exceed the cutoff scores must be informed that the student therapist is required to consult with their supervisor to ensure appropriateness, and that the client will be informed if a referral needs to be made. However, student therapists should still schedule a second appointment with the client, especially if they feel that the client is appropriate for services even though they exceeded the cutoff. The completed form should be uploaded to the client file.

ALL SCREENING IS TO BE DONE INDIVIDUALLY WITH EACH ADULT CLIENT, WITH NO ONE ELSE IN THE ROOM

Drug and Alcohol and Drug Screening (CAGE-AID)

Please read the following questions out loud and record the patient's answers.

Have you ever felt you ought to cut down on your drinking or drug use? YES NO

Have people annoyed you by criticizing your drinking or drug use? YES NO

Have you felt bad or guilty about your drinking or drug use? YES NO

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? YES NO

Scoring: Item responses on questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol and/or drug problems.

Score: _____

A total score of two or greater is considered clinically significant; you should consult your clinical Supervisor if the identified patient obtains this score and if their substance use is current.

HITS Tools for Intimate Partner Violence

This measure is to be administered one-on-one with clients who report that they have a current partner or partners

Please read each of the following activities, pick the box that best indicates the frequency with which their partner acts in the way depicted.

Does your partner physically hurt you?

1. Never
2. Rarely
3. Sometimes
4. Fairly often
5. Frequently

Does your partner threaten you with harm?

1. Never
2. Rarely
3. Sometimes
4. Fairly often
5. Frequently

Does your partner insult or talk down to you?

1. Never
2. Rarely
3. Sometimes
4. Fairly often
5. Frequently

Does your partner scream and/or curse at you?

1. Never
2. Rarely
3. Sometimes
4. Fairly often
5. Frequently

Total the numbers in front of the responses that were circled. The maximum score is 20.

Score: _____

Individuals with scores of 10 or above total; or scoring "sometimes" or higher on questions 1 and/or 2 will require Supervisor approval.

Mental Health Screening

Has the identified patient ever been diagnosed with a severe mental illness such as:

Schizophrenia	YES	NO
Paranoia and other psychotic disorders	YES	NO
Bipolar disorders (hypomanic, manic, depressive, and mixed)	YES	NO
Schizoaffective disorders (bipolar or depressive)	YES	NO
Personality Disorder (borderline personality disorder, antisocial personality disorder, narcissistic personality disorder)	YES	NO

Other: _____

A yes answer to any of these requires discussion with your Supervisor

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS		Past 3 months	
Ask questions that are bolded and <u>underlined</u> .		YES	NO
Ask Questions 1 and 2			
1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		Low Risk	
2) <u>Have you actually had any thoughts of killing yourself?</u>		Low Risk	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.			
3) <u>Have you been thinking about how you might do this?</u> E.g. "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."		Moderate Risk	
4) <u>Have you had these thoughts and had some intention of acting on them?</u> As opposed to "I have the thoughts but I definitely will not do anything about them."		High Risk	
5) <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>		High Risk	
6) <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. If YES, ask: <u>Was this within the past three months?</u>		High Risk	Moderate Risk

- Low Risk
- Moderate Risk
- High Risk

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