Transforming Through Therapy

Dr. Galana Chookolingo, Ph.D., LPC
NC Licensed Counseling Psychologist, 5537
CA Licensed Psychologist PSY30181
PA Licensed Professional Counselor PC007484
Phone: 619-664-4197 / Website: GChookolingoPhD.com
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Dear Prospective Client,

Attached to this letter are several additional important documents and forms that I request you read and complete before our first appointment.

- Pages 2-3 Consent for Treatment/Privacy Notice
- Pages 4-5 Consent for Telehealth Consultation
- Page 6 Missed Appointment/Late Cancellation Policy
- Page 7 Release of Information for Emergency Contact (if you are seeing a Psychiatrist, please let me know and I will add a form)
- Page 8 Client Contact information
- Pages 9-10 Initial Intake Information (Skip page 11)
- Page 12 Safety Plan
- Page 13 Patient Health Questionnaire (9 items)
- Page 14 Anxiety Questionnaire (7 items)
- Page 15 Suicide Behaviors Questionnaire (4 items)
- Page 16 Drug and Alcohol Assessment (13 items)
- Page 17 ACE Survey (10 items)

Thank you in advance for taking the time to review and sign these documents. I am happy to answer any questions during our meeting. Please fax/upload all of these forms to me prior to our first session. Since I will be using telehealth for all of our meetings, it is important that we have local emergency information for you (your primary care physician, a local emergency room should any emergencies arise) and a thorough initial assessment, which is why there are specific forms for this. Please let me know if you have any concerns.

Thank you and I look forward to meeting you.

Sincerely,

Galana Chookolingo, Ph.D., LPC

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Notices of Privacy Practices

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you is protected, and also how it may be used and disclosed. During the process of providing services, Dr. Galana Chookolingo, Ph.D., at Transforming Through Therapy will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as described below.

USES, DISCLOSURES, AND COMMUNICATION OF PROTECTED INFORMATION

A. **General Uses and Disclosures Not Requiring the Patient's Consent.**
    1. **Treatment:** Treatment refers to the provision, coordination, or management of healthcare (including mental healthcare) and related services. During treatment, the provider may consult with other providers, without identifying you by name, and also not disclosing any other identifying information about you, in order to ensure the best care possible for your concerns.
    2. **Payment:** Payment refers to the activities undertaken by the provider to obtain or provide reimbursement for the provision of healthcare. For example, the provider will use your information to develop accounts receivable information, to bill you, and with your consent, to bill third parties. If you elect to have a third party pay for your treatment, the information provided to the third party may include information that identifies you as well as your diagnosis, type of service, date of service, and other information about your condition and treatment.
    3. **Contacting the Patient:** The provider may contact you to remind you of appointments, or to change or cancel appointments. The provider may leave messages on voicemail or with other parties, identifying the name and phone number of the provider. The provider will use best judgment in the details left on a voicemail. If you do not want the provider leaving messages, or if you wish to restrict messages in any way, please notify the provider in writing.
    4. **Required by Law:** The provider will disclose protected health information when required by law or when necessary for healthcare oversight. This includes, but may not be limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the patient is a danger to self, others, or is gravely disabled, or (e) reporting elder abuse or dependent person abuse.
    5. **Family Members:** Except for certain minors, protected health information cannot be provided to family members without the patient's consent. In situations where family members are present

during a discussion with the patient, and it can be reasonably inferred from the circumstances that the patient does not object, information may be disclosed in the course of that discussion. However, if the patient objects, protected health information will not be disclosed.

6. **Emergencies:** In life-threatening emergencies, the provider will disclose information necessary to avoid serious harm or death.

B. Patient Authorization or Release of Information:

The provider may not use or disclose protected information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent the provider has already taken action in reliance thereon.

C. Alternative Means of Receiving Confidential Information:

You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider to mail statements or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests. You will also have to pay any additional costs that may be associated with such a request.

Protection of Confidential Information: The provider has taken steps to protect the confidentiality of your information, including the use of name-codes, password protection of computer files, locked file cabinets, paper shredding, and other security measures. Your files will be destroyed (shredded or incinerated) when past the time required for the maintenance of such records (e.g. 7 years after termination of therapy or 7 years after the client turns 18, whichever is later).

I hereby acknowledge that I have received a copy of the provider's Notice of Privacy Rights.

____

Client's Name

____

Client Signature (Parent or Responsible Party and Relationship) Date

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CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE TELEHEALTH WITH TRANSFORMING THROUGH THERAPY

Telehealth with Transforming Through Therapy uses doxy.me as the technology service we will use to conduct telehealth videoconferencing appointments.

By signing this document, I acknowledge:

1. Telehealth by Transforming Through Therapy is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Transforming Through Therapy nor doxy.me provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by doxy.me facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by doxy.me – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by doxy.me.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- ***That I have read or had this form read and/or had this form explained to me.***
- ***That I fully understand its contents including the risks and benefits of the procedure(s).***
- ***That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.***

____

Client's Name Date of Birth Physical Location

____

Client Signature (Parent or Responsible Party and Relationship) Date

____

Clinician's Signature Physical Location

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Missed Appointment/Late Cancellation Charges

By signing below, I acknowledge that I am responsible for payment of charges by Dr. Galana Chookolingo, Ph.D., at Transforming Through Therapy for not showing up to an appointment without at least 24-hour notice of cancellation. I acknowledge that effective ________________, the amount which I am responsible in the event of a late cancelled or missed appointment is $50 per 45-50/minute session. I agree to pay this amount within 30 days of my late cancelled or missed appointment. In cases of stored credit cards, I authorize the provider to charge my credit card.

____

Client's Name

____

Client Signature (Parent or Responsible Party and Relationship) Date

____

Clinician's Signature

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Authorization for Release of Information

Client Name: ___________________________________ Date of Birth: ____________________

I, ________________________________, hereby authorize Dr. Galana Chookolingo and Transforming Through Therapy

to exchange information, regarding my treatment to: ____.
(Emergency Contact name, phone, email)

The type of information to be disclosed:

○ Evaluations
○ Psychological Notes
○ Test Results
○ Diagnosis
○ Treatment Plan
○ Mental Health Record
○ Summary
○ Course of Treatment
○ Other: ______________________

The purpose of such disclosure:

○ Ongoing treatment
○ Medical Care
○ Consultation
○ Transfer of Care
○ Legal Issues
○ Coordination of Care
○ Health Benefit
○ Utilization
○ Other: ___________________

The designated information about me ○ **may** ○ **may not** be transmitted by fax, electronic mail, or other electronic file transfer mechanisms. Also, the above designated person ○ **may** ○ **may not** discuss by telephone the content of the information released.

This consent is effective until ______________________. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed professionals, except as previously explained to me. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of a child, elder, or dependent adult.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

____
Client's Signature Date

____
Clinician's Signature Date

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Client Contact Information

○ *Copy of ID*

Client Name: ____ Gender: ____________________

Date of Birth: _______________________________________

Parent/Guardian (if under 18): ____

Mailing Address: ____

City/State/Zip: ____

Email Address: ____

Okay to email for scheduling appointments? ○ Yes ○ No

Home Phone: _______________________ Okay to leave detailed message? ○ Yes ○ No

Work Phone: _______________________ Okay to leave detailed message? ○ Yes ○ No

Other Phone: _______________________ Okay to leave detailed message? ○ Yes ○ No

---

Emergency Contact Name: __________________________________ Phone: _______________________

Mailing Address: __________________________________ City/State/Zip: _________________________

By signing below, I agree to the following: (1) I understand that the client is ultimately responsible for the cost of all services rendered; (2) I will pay the appropriate fee at the time service is rendered; (3) I understand that I will be billed a fee of $50 for missed appointments that are not canceled at least 24 hours in advance and that I am responsible for paying those charges; (4) I agree to pay for all costs of collection of the client's delinquent accounts including reasonable attorney fees; (5) I agree that if my mailing address is written incorrectly, has changed since the date of this form, or is missing from this form, I may receive a bill at a current and verifiable address for any outstanding charges.

Client Signature ____ Date _______________________

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Client Name: ____ Gender: __________

Date of Birth: _______________________________________ Date of Evaluation: __________

Reason for seeking counseling:

Check current clinical symptoms:

○ Addictive Behavior
○ Aggression/Violence
○ Alcohol/Substance Use
○ Anger/Irritability
○ Anxiety/Panic
○ Appetite Problems
○ Binging/Purging
○ Bizarre Behavior
○ Chronic Medical Problems
○ Culture/Race Concerns
○ Stressed/Feeling Overwhelmed

○ Depression
○ Destructive Behavior
○ Gender Identity Concerns
○ Grief/Loss
○ Homicidal Ideation
○ Isolation/Withdrawal
○ Suicidal Ideation
○ Self-Harming Behavior
○ Mood Swings
○ Obsessions/Compulsions
○ Tearful/Crying Spells
○ Poor Impulse Control

○ Post Traumatic Stress
○ Problems Thinking/ Concentrating
○ Relationship Concerns
○ Sexual Activity Concerns
○ Sexual/Intimacy Issues
○ Sexual Identity Concerns
○ Sleep Disturbance
○ School Concerns
○ Identity Development
○ Other _________________

Past counseling: ○ Yes ○ No

If yes, please indicate dates, whether inpatient/outpatient, problem for which you were treated, and name of treating professional:

____
____
____
____

Please list any allergies/drug sensitivities: ____

Current Medications and Dosage: ____

Name and Phone Number of Prescribing Professional: ___________________________________

If not on medication, would you like a referral for a medical evaluation? ○ Yes ○ No

Name and Phone Number of Primary Care Physician (PCP): _______________________________

Permission to Contact PCP regarding Treatment? ○ Yes ○ No

Substance Use (Indicate Past/Present)

○ Tobacco
○ Alcohol
○ Marijuana
○ Cocaine
○ Opiates
○ Benzodiazepine
○ Club Drugs
○ Other (please list)
____

Strengths:

____
____
____
____

Goals for Counseling:

____
____
____
____

Any other information you would like to share?

____
____
____
____
____
____
____
____

For Clinical Use Only (<u>do not write in this space</u>):
Identifying Data:

Family:

Social/Relationship:

General Functioning:

Education:

Trauma/Abuse:

Assessment/Summary:

Plan:

Diagnostic Impressions:

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Safety Plan

Telehealth is not an appropriate mode of therapy for crisis services.

If you need immediate assistance outside of your regularly scheduled appointment, please go to the nearest emergency room or call 911.

The three people that I can call for support are (name and phone number):

1. ______________________________
2. ______________________________
3. ______________________________

Three things that I can do to help me cope or can provide distraction are:

1. ______________________________
2. ______________________________
3. ______________________________

My nearest emergency room is located: ______________________________

My primary care physician is: ______________________________

National Suicide Help Line: 1-800-273-8255

Crisis Text Line: Text START to 741-741

I have willingly participated in the process of creating the safety plan and received a copy. I intend to follow the plan and follow up with a mental health provider.

____

Client's Name | Date of Birth | Physical Location

____

Client Signature (Parent or Responsible Party and Relationship) | Date

____

Clinician's Signature | Physical Location

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PHQ-9

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

		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 of 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 at home, or get alone with other people? (Circle One)

Not difficult at all Somewhat difficult Very difficult Extremely difficult

For office coding 0 + _____ + _____ + _____ = _____ (Total Score)

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.

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GAD-7

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

		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
7.	Feeling afraid as if something awful might happen	0	1	2	3

For office coding 0 + _____ + _____ + _____ = _____ (Total Score)

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Suicide Behaviors Questionnaire—Revised

Please check the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself?
___ *Never*
___ *It was just a passing thought*
___ *I have had a plan at least once to kill myself but did not try to do it*
___ *I have had a plan at least once to kill myself and really wanted to die*
___ *I have attempted to kill myself, but did not want to die*
___ *I have attempted to kill myself, and really hoped to die*

2. How often have you thought about killing yourself in the past year?
___ *Never*
___ *Rarely (1 time)*
___ *Sometimes (2 times)*
___ *Often (3-4 times)*
___ *Very often (5 or more times)*

3. Have you ever told someone that you were going to commit suicide, or that you might do it?
___ *No*
___ *Yes, at one time, but did not really want to die*
___ *Yes, at one time, and really wanted to die*
___ *Yes, more than once, but did not want to do it*
___ *Yes, more than once, and really wanted to do it*

4. How likely is it that you will attempt suicide someday?
___ *Never*
___ *No chance at all*
___ *Rather unlikely*
___ *Unlikely*
___ *Likely*
___ *Rather likely*
___ *Very likely*

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AUDIT-C Alcohol Questionnaire

by the World Health Organization

1. How often do you have a drink containing alcohol? (check the most applicable response)
___ never ___ monthly or less ___ 2-4 times a month ___ 2-3 times a week ___ 4+ times a week

If you drink alcohol, please answer these additional questions:

2. How many standard drinks containing alcohol do you have in a typical day?
___ 1 or 2 ___ 3 or 4 ___ 5 or 6 ___ 7 to 9 ___ 10 or more
3. How often do you have six or more drinks on one occasion?
___ never ___ less than monthly ___ monthly ___ weekly ___ daily or almost daily

DAST-10 Drug Use Questionnaire

by Harvey A. Skinner, Department of Health Sciences, University of Toronto

The following questions pertain to your use of drugs during the past 12 months. In responding to these questions do not include your use of alcohol, but do include any prescription medications you take that are *not* prescribed to you or that you use in ways do not adhere to the instructions provided by your prescriber.

Circle YES or NO in responding to the following questions:

1. Have you used drugs other than those required for medical reasons? YES NO

If YES, please answer these additional questions:

2. Do you abuse more than one drug at a time? YES NO
3. Are you always able to stop using drugs when you want to? YES NO
4. Have you had *blackouts* or *flashbacks* as a result of your drug use? YES NO
5. Do you ever feel bad or guilty about your drug use? YES NO
6. Does your partner or spouse or do your parents ever complain about your involvement with drugs? YES NO
7. Have you neglected your family because of your use of drugs? YES NO
8. Have you engaged in illegal activities in order to obtain drugs? YES NO
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? YES NO
10. Have you had medical problems because of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? YES NO

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What's My ACE Score?

Prior to your 18th birthday:

1. Did a parent or other adult in the household **often** …
   a. Swear at you, insult you, put you down, or humiliate you? ***or***
   b. Act in a way that made you afraid that you might be physically hurt?
2. Did a parent or other adult in the household **often** …
   a. Push, grab, slap, or throw something at you? ***or***
   b. Ever hit you so hard that you had marks or were injured?
3. Did an adult or person at least 5 years older than you **ever**…
   a. Touch or fondle you or have you touch their body in a sexual way? ***or***
   b. Try to or actually have oral, anal, or vaginal sex with you?
4. Did you **often** feel that …
   a. No one in your family loved you or thought you were important or special? ***or***
   b. Your family didn't look out for each other, feel close to each other, or support each other?
5. Did you **often** feel that …
   a. You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? ***or***
   b. Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
6. Were your parents ever separated or divorced?
7. Was your mother or stepmother:
   a. **Often** pushed, grabbed, slapped, or had something thrown at her? ***or***
   b. **Sometimes** or **often** kicked, bitten, hit with a fist, or hit with something hard? ***or***
   c. **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
10. Did a household member go to prison?

Now add up your "Yes" answers: _______. This is your ACE Score