THERAPYWORKS

128 Newberry Ave. Libertyville, IL 60048 (847) 680-0272

MARK SOLOMON, PSY. D.
CLINICAL PSYCHOLOGIST

CAROL SOLOMON, PH. D.
CLINICAL PSYCHOLOGIST

www.therapyworks-online.com

Thank You for your interest in being seen at Therapyworks.

As a start to our work together, please print out the following forms and consent documents.

This includes the following:

Patient orientation handout/therapy contract/assignment of benefits sheet

Patient information sheet

History and Factors Questionnaire

Family History

Depression/Anxiety checklists

Please bring the completed materials with you to our first meeting and/or drop the packet at the office prior to our first meeting (ask the secretary to put it in my mailbox).

Sincerely,

Mark Solomon, Psy. D

Clinical Psychologist
Therapyworks

Patient Contract

Welcome to Therapyworks. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting.

Once you sign this, it will constitute a binding agreement between us.

PSYCHOLOGICAL SERVICES

Therapy is not easily defined. It varies depending on the personalities of the therapist and the patient, and the particular problems to be addressed. There are a number of different approaches that can be used to address the problems you hope to address. It is not like visiting a medical doctor, in that psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work both during our sessions and at home between sessions.

Psychotherapy has both benefits and risks. It often leads to a significant reduction of feelings of distress, better relationships and resolutions of specific problems. But there are no guarantees about what will happen. Risks include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy sometimes requires recalling unpleasant aspects of your history. Sometimes people experience unanticipated changes in their relationships. Most people feel that the benefits of psychotherapy outweigh the risks.

At the beginning of our meetings there is an evaluation period which will last from 2 to 4 sessions. During this time, we can both decide whether I am the best person to provide the services that you need in order to meet your treatment objectives. By the end of the evaluation, I will be able to offer you some initial impressions of what our work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy so you should be very careful about the therapist you select. If you have questions about my procedures or policies, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you seek another mental health professional.

APPOINTMENTS

Initial sessions are usually 1 hour and further sessions are generally scheduled for 45-minutes; this is the standard "psychotherapy hour". Because the appointment time is reserved for you, another patient cannot readily fill it. Once this appointment time is scheduled, you will be expected to provide 24 hours advance notice of cancellation. If you do not provide 24 hours notice, you will be expected to pay a **missed appointment fee** of $50.00 unless we both agree that you were unable to attend due to circumstances that were beyond your control. Research has repeatedly demonstrated that progress in therapy is closely related to the commitment to the therapy process and the regularity of appointments. Please do not cancel your appointments unless absolutely necessary.

PROFESSIONAL FEES

Our standard fee is $175.00 for an initial session and $125.00 for further sessions unless we have another agreement with you or your insurance company. In addition to scheduled appointments, it is our practice to charge this fee on a prorated basis for other types of professional services that you may require. Examples of services we generally bill for would include report writing, attendance at meetings or consultations with other professionals, preparation of records or treatment summaries, or the time required to perform any other extended service which you may request of us.

You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage that requires another arrangement. In cases where insurance is billed by our office, payment of deductibles and co-payments are expected at the time of service.

If your account is more than 60 days past due, and suitable arrangements for payment have not been agreed to, we have the option of using legal means to secure payment and/or to discuss other treatment options that are less costly.

HOW TO CONTACT US

We are often not immediately available by telephone. Our office hours vary and we usually do not answer the phone when we are with a client. When we are unavailable, our telephone is answered by voice mail that we monitor frequently. We will make every effort to return your call within 24 hours with the exception of weekends and holidays. If you are difficult to reach, please leave some times that you will be available. If we are unavailable for an extended time, we will provide you with the name of a trusted colleague whom you may contact if necessary.

EMERGENCIES

In case of an emergency, I can be reached by calling **(224) 513-1225. Either I will answer or leave a voice message with a number where you can be reached.**

CONFIDENTIALITY

In general, mental health law, including **HIPPA**, protects the confidentiality of all communications between a client and a psychologist, and we can only release information about our work to others with your written consent. **Confidentiality applies to children and teens** as well as adults. In most judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances, a judge may require our testimony if he/she determines that resolution of the issues before him/her demands it.

Part of our psychotherapy agreement is a policy to reveal nothing about any person except under conditions of consent by the person or the person's legal representative. There are, however, some exceptions to this policy. **Exceptions to confidentiality include the following:**

1) Circumstances in which maintaining strict confidentiality would result in danger to the patient in treatment or others

2) Circumstances which involve the direct disclosure of or suspected presence of child abuse and/or neglect

3) Circumstances involving insurance or managed care, in which clinical information is shared in order to authorize treatment

4) Circumstances involving military personnel in which federal law dictate standards of confidentiality

In any situation where disclosure is involved, efforts will be made to inform such persons and secure their cooperation.

We may occasionally find it helpful to consult about a case with other professionals or each other. In these consultations, we make every effort to avoid revealing the identity of our client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, we will not tell you about these consultations unless we feel that it is important to our work together.

A word about PAYMENT AND INSURANCE

It is our policy to openly discuss fees and insurance benefits with you. The escalation of health care costs and the use of "managed health care" have made it difficult to determine, in some cases, how much mental health care coverage is available. It has been our experience that people are often surprised and disappointed by what their actual benefits are compared to what they thought they were. Therefore, it is our policy to help you confirm your mental health coverage and benefits.

If you have health insurance, it will usually provide some coverage for mental health treatment. Insurance carriers vary widely in their benefits for psychotherapy. We encourage you to be familiar with your policy coverage for mental health services, which often differs from general medical coverage. In part, setting realistic goals in psychotherapy involves an understanding of what your resources (insurance and/or otherwise) allow.

"Managed care plans" such as HMOs and PPOs often require authorization before they will provide reimbursement for mental health services. These plans are often oriented towards a short-term treatment approach designed to resolve specific problems that interfere with one's usual level of functioning. While much can be accomplished in short-term therapy, some clients feel that more sessions are necessary after insurance benefits end.

We will help you get reimbursement in any way that we can. However, we cannot guarantee that your insurance company will cover our services and you (not your insurance company) are responsible for payment of the fee that you have agreed to. Once we have all of the information

about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if the benefits run out before you feel ready to end our sessions. **Some people prefer the option of paying for our services themselves and avoiding the problems described above.**

You should also be aware that **most insurance agreements require you to authorize us to provide a clinical diagnosis, and additional clinical information such as a treatment plan or summary.** Managed care companies are generally authorized to receive a copy of your entire record if they so request. Information sent for case management will become part of the insurance company's files, and in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, we have no control over what they do with it. In some cases, they may share the information with a medical information data bank.

YOUR SIGNATURE ON THE THERAPY CONTRACT indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. If you have any questions, please bring them up at any time.

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Therapy Contract Agreement

Patient Name:_____

I have read the Therapyworks Patient Orientation handout and understand the general purpose and process of psychotherapy. I further understand the conditions and limits of confidentiality. I recognize that psychotherapy is a process that is frequently associated with experiencing strong negative feelings, as well as positive feelings, and sometimes changing relations with others due to personal changes made during therapy.

Assignment and Instruction for Payment to Doctor

I hereby authorize Therapyworks to release information as deemed necessary for my treatment to the person/institution who referred me, when applicable, and my insurance company.

I instruct and direct my insurance company to make payment of all claims that would otherwise be forwarded to me directly to:

Therapyworks
128 Newberry Ave.
Libertyville, IL. 60048
TIN # 36-3937596

_____ Date:_____
Signature of Policyholder

_____ Date:_____
Signature of Claimant, if other than Policyholder

Patient Information -- Adult

Date: ______________________

Name of Patient: ____

Name of insured: ____

Patient's Birthdate: ______________________________ Age: _________________

Insured's S.S.#: ____

Patient's Address: ____

____

Telephone: Home ________________________ Work __________________________

Email (Print v-e-r-y clearly) ____

Employment: ____

What doctor regularly cares for you? ____

Who referred you to see me? ____

For Office use only
****
*

Insurance Coverage: ____

Deductible: **Co-Pay**: **Year Max**: **Life Max**:

Precert: Yes No

Ind TX Yes No **FAM TX** Yes No **Psych Test** Yes No

Diagnosis: ____

History and Factors Questionnaire – Adult

Your Name: _____

Please state in your own words the nature of your current concerns/problems:

_____
_____
_____
_____
_____
_____
_____
_____
_____

On the scale below, please estimate (circle) the severity of your problems:

Mildly Upsetting **Moderately Upsetting** **Very Severe**
Extremely Severe **Totally Incapacitating**

3. When did your problems begin?

4. Did you ever seek treatment for these problems before? Yes No

If yes, please explain when treatment was sought and the results of treatment

_____
_____
_____
_____

5. Did your parents ever take you to see anyone about these problems when you were a child or adolescent?

Yes No

6. What is the highest level of school that you have completed (circle)?

Jr. High High School Some College College Postgraduate

7. Did you ever have difficulty in school? Yes No

8. Did you ever have problems with your temper? Yes No

9. Have you ever lost your temper and hurt anyone or damaged any property? Yes No

10. Do other people ever complain about your temper? Yes No

11. How would you describe your mood most of the time?

Normal/Stable Anxious/Nervous Depressed/Sad Labile/Moody Other

12. Do you have any problems with your sleep? Yes No

13. Do you have any problems with your weight? Yes No

14. How much alcohol do you drink in a week

Don't drink at all 0-1 drink 2-4 drinks 5-10 drinks More than 10 drinks

15. Did you ever drink more heavily Yes No

16. Have you ever used drugs recreationally? Yes No

17. Do you use any drugs recreationally now? Yes No

18. Have you ever misused any prescription or over the counter drugs? Yes No

Medical History

19. Do you have any current medical problems? (**include allergies**) Yes No

If yes, please explain

20. Have you ever been hospitalized? Yes No

21. Do you currently take any medication? Yes No

If yes, please list medication(s) and dose(s)

Risk Assessment Screen (Adult)

Do you ever worry that you might physically hurt somebody else?	Yes	No
If yes, please explain.		
Have you ever threatened to seriously harm someone else?	Yes	No
Do you lose your temper easily?	Yes	No
Are you argumentative, defiant or disobedient?	Yes	No
Are you spiteful or vindictive?	Yes	No
Do you initiate fights or destroy other's property?	Yes	No
If yes, please explain.		
Have you ever used a weapon in a fight?	Yes	No
Have you ever been arrested or detained by the authorities?	Yes	No
If yes, please explain.		
Do you ever worry that you might harm yourself or others?	Yes	No
Have you ever expressed thoughts of death or suicide?	Yes	No
Have you ever made a suicide attempt?	Yes	No
Do you engage in dangerous activities (e.g. reckless driving)?	Yes	No
Have you ever acted cruel towards animals?	Yes	No
Has your family (growing up or current) had any contact with DCFS	Yes	No
If yes, please explain.		

Symptom/Diagnostic Criteria:

Please put a check mark for any of the following problems you have at this time.

_____ Fidgets
_____ Difficulty remaining seated
_____ Easily distracted
_____ Difficulty awaiting turn
_____ Difficulty following instructions
_____ Difficulty sustaining attention
_____ Often blurts out answers to questions before they have been completed
_____ Shifts from one activity to another
_____ Difficulty working or playing quietly
_____ Often talks excessively
_____ Often interrupts or intrudes on others
_____ Often does not listen
_____ Often loses things
_____ Often engages in physically dangerous activities

Total for ADHD_____(8 or more)

When did these problems begin? (Specify age):

_____ Unrealistic worries about future event
_____ Unrealistic concern about appropriateness of past behavior
_____ Unrealistic concern about competence
_____ Somatic complaints (headaches, stomachaches, etc.)
_____ Marked self-consciousness
_____ Excessive need for reassurance
_____ Marked inability to relax

Total for Overanxious Disorder_____(4 or more)

_____ Depressed mood for most of the day for at least 2 years
_____ Poor appetite or overeating
_____ Sleep problems (e.g. insomnia or hypersomnia)
_____ Low energy or fatigue
_____ Low self-esteem
_____ Poor concentration or difficulty making decisions
_____ Feelings of hopelessness
_____ Never without these symptoms for more than 2 months over a 2 year period

Total for Dysthymia _____ (4 or more, must include 1 and 8)

_____ Depressed or irritable mood most of day, nearly every day, for 2 or more weeks
_____ Diminished pleasure in activities nearly every day for 2 or more weeks
_____ Increase or decrease in appetite with associated change in weight
_____ Poor sleep or too much sleep nearly every day
_____ Psychomotor agitation or retardation
_____ Fatigue or loss of energy
_____ Feelings of worthlessness or excessive inappropriate guilt
_____ Diminished ability to think or concentrate (indecisiveness)
_____ Suicidal ideation or attempt

Total for Major Depressive Episode_____ (**5 or more, must include 1 or 2**)

How long have you had these symptoms?

_____ Feelings change quickly and often expressed strongly
_____ Explosive temper with minimal provocation
_____ Excessive clinging, attachment, or dependence on adults
_____ Unusual fears
_____ Strange aversions
_____ Panic attacks
_____ Excessively constricted or bland affect (don't show feelings)
_____ Situationally inappropriate emotions (feelings don't match situation)

Total for r/o Bipolar or Panic disorder _____

Family History Review Form - Adult

Please place an X on the chart below for family members who exhibit any of the following problems:

	Father's Family	Mother's Family	You	Your Siblings	Your Children
Seizures or convulsions	[ ]	[ ]	[ ]	[ ]	[ ]
Hyperactive as a child	[ ]	[ ]	[ ]	[ ]	[ ]
Problems with attention, or impulse control	[ ]	[ ]	[ ]	[ ]	[ ]
Learning disabilities (e.g. reading, math, writing)	[ ]	[ ]	[ ]	[ ]	[ ]
Kept back in school, or did not graduate high school	[ ]	[ ]	[ ]	[ ]	[ ]
Mental retardation	[ ]	[ ]	[ ]	[ ]	[ ]
Psychosis or schizophrenia	[ ]	[ ]	[ ]	[ ]	[ ]
Depression for greater than 2 weeks and/or Mania	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety that impaired day to day living	[ ]	[ ]	[ ]	[ ]	[ ]
Muscle tics/twitches or Rituals (washing/checking)	[ ]	[ ]	[ ]	[ ]	[ ]
Alcohol/substance abuse	[ ]	[ ]	[ ]	[ ]	[ ]
Antisocial behavior such as assaults, thefts, etc.	[ ]	[ ]	[ ]	[ ]	[ ]
Physically or sexually abused	[ ]	[ ]	[ ]	[ ]	[ ]
Suicide Attempt	[ ]	[ ]	[ ]	[ ]	[ ]

Please use this space to explain any of the above conditions, or inform us about any other family problem that may have a social or hereditary bearing.

_____
_____
_____
_____

BURNS DEPRESSION CHECKLIST

Place an X in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

	0 **Not at All**	1 **Somewhat**	2 **Moderately**	3 **A Lot**
1. **Sadness:** Do you feel sad or down in the dumps?				
2. **Discouragement:** Does the future look hopeless?				
3. **Low self-esteem:** Do you feel worthless?				
4. **Inferiority:** Do you feel inadequate or inferior to others?				
5. **Guilt:** Do you get self-critical and blame yourself?				
6. **Indecisiveness:** Is it hard to make decisions?				
7. **Irritability:** Do you frequently feel angry or resentful?				
8**. Loss of interest in life:** Have you lost interest in your **career, hobbies,** family, or friends?				
9. **Loss of motivation:** Do you have to push yourself hard to do things?				
10. **Poor self-image:** Do you feel old or unattractive?				
1 1. **Appetite changes:** Have you lost your appetite? Do you overeat or binge compulsively?				
12. **Sleep changes:** Is it hard to get a good night's sleep? Are you excessively tired and sleeping too much?				
13. **Loss of sex drive:** Have you lost your interest. in sex?				
14. **Concerns about health:** Do you worry excessively about your health?				
15. **Suicidal impulses:** Do you have thoughts that life is not worth living or think you'd be better off dead?				

Total score on items 1-15

Name:

BURNS ANXIETY Checklist

Place an **X** in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

Category 1: Anxious Feelings	0 Not at All	1 Somewhat	2 Moderately	3 A Lot
1. Anxiety, nervousness, worry, or fear				
2. Feeling that things around you are strange or unreal				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight," or on edge				
Category II: Anxious Thoughts	0 Not at All	1 Somewhat	2 Moderately	3 A Lot
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening fantasies or daydreams				
10. Feeling that you're on the verge of losing control				
1 1. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of illnesses, heart attacks or dying				
14. Concerns about looking foolish or inadequate				
15. Fears of being alone, isolated, or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen.				

Category III: Physical Symptoms	0 Not at All	1 Somewhat	2 Moderately	3 A Lot
18. Skipping, racing, or pounding of the heart (palpitations)				
19. Pain, pressure, or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded, or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak, or easily exhausted				

Name:

Date: