REBUILDING HOPE! SEXUAL ASSAULT CENTER for PIERCE COUNTY

Therapy Services
Policy & Disclosure Statement

Welcome to Rebuilding Hope! The Sexual Assault Center for Pierce County. We would like you to be knowledgeable about our agency and your rights as a client. Your signature on this form acknowledges that you have read and understand the provided information.

Services: We provide a range of services for adolescents and adults, including individual, couples, family, and group therapy. Therapy services are available for survivors, their friends, partners, and families. Therapy may be used to address imminent and critical concerns or it may focus on more long term adjustment.

You have the right to be treated with dignity and respect, and the right to care that does not discriminate and is sensitive to gender, ethnicity, sexual orientation, age, creed, and economic status. Under specific conditions, you have the right to review your case record. You have the right to receive written information about your therapist's training and experience. You have the right to review your treatment plan.

Your participation is voluntary. You have the right to request referral to a different therapist, either within the agency or elsewhere. You have the right to conclude counseling at any time.

We will not provide therapy services in the following situations: custody evaluations, psychiatric evaluations, medication monitoring, expert witness capacity, sex offender treatment, or for children under the age of 13 years. We do not undertake therapy for the sole purpose of retrieving "lost" memories. Additional assessment to determine appropriateness of service will be made regarding alcohol/substance use, eating disorders, particular psychiatric conditions and the vulnerability to self harm.

Confidentiality: Your treatment here is confidential. Information about you (including the fact that you have been seen here) will not be released unless you give us written permission to do so. If we have reason to believe that you may be a danger to yourself and to others, that you are unable to care for your basic needs, that you may be abusing a child or adult dependent, or that you are HIV positive and may be engaging in behavior that could infect others, we are required by law to release that information.

Clients that are age 13-17 and are responsible for their own fees do not need parental consent for therapy services at *Rebuilding Hope*. Parents/guardians that are responsible for *Rebuilding Hope* fees for their 13-18 year-old children do need to sign a parental consent form. Regardless of parental consent, parents of clients age 13-18 may be notified if the client is indicating suicidal risk or serious ideation.

Your therapist may consult with *Rebuilding Hope* staff or with other professionals during case consultation and supervision. Information discussed at that time is for the purpose of treatment planning and will remain confidential.

Fees: There is a $90 charge per therapy session. It is your responsibility to determine if our services are covered and to bill your insurance company. If you unable to pay this amount, please discuss our sliding fee scale with the therapist. There will be a $15 fee for returned checks or debit cards that are not approved.

Disclosures: All counselors with *Rebuilding Hope* are licensed or registered by the state of Washington. You will be provided with an individual disclosure form for your counselor. All counseling staff are trained at the Master's level, receive regular supervision and meet annual education requirements, or are Master's level interns.

Counselors are accountable for their work with you. If you have concerns about the course of your therapy, you are encouraged to discuss them with your counselor. If your concerns are related to unethical or unprofessional conduct, the Clinical Director of Therapy Services or the Executive Director of the agency is available. You may also send a letter to the state of Washington Department of Professional Licensing.

Appointments: Individual counseling sessions are usually 50 minutes long. The length of group sessions are 1-1/2 to 2 hours in length. Individual and group counseling generally occurs on a weekly basis. Because *Rebuilding Hope* has a waiting list, please provide at least 24 hour notice if you need to cancel or change an appointment. Please note there may be a missed appointment fee if you cannot reschedule into the same week with your therapist.

If you must miss an appointment and fail to provide 24-hour notification, you will be charged our "missed appointment fee," which will be determined at the time of intake.

Messages: Messages may be left for therapists on their individual extension at the *SACPC* administrative office (253-597-6424) and your therapist will call when able to do so. Therapists are not available 24-hours a day; however, we maintain a 24-hour telephone crisis and information line (253-474-7273; 1-800-756-7273). In an emergency, you may call 911 or go to the nearest hospital emergency room.

My signature allows for the release of appropriate therapy information to insurance companies, Crime Victims Compensation (L & I) and other funding sources as needed.

I have read and understand the information provided in this document about my rights and responsibilities while working with SACPC. Further, I know that SACPC recognizes that the capacity for memory relies on a variety of factors. This agency makes no assumptions regarding the accuracy of my stated memories.

_____ _____

Signature Parent/Guardian Signature if indicated

_____

Date

_____

Witness

HOPE! SEXUAL ASSAULT CENTER

Fee and Cancellation Policy

Rebuilding Hope, the Sexual Assault Center for Pierce County, is a non-profit agency. This means that all fees collected go back into helping other sexual assault victims. Grants, donations, and fees for services help to cover your cost of treatment.

The amount of funding we get is often dependent on the number of clients we see. This means that if you miss an appointment, we must still pay our expenses, but we do not potentially get the same amount of funding to cover our costs. The following policies are not meant to cause you hardship, but to ensure that services continue to be available for you and other survivors.

Attending therapy appointments on a regular basis is necessary if you want your therapy to be the most beneficial. By contracting to begin therapy, you are agreeing to keep your appointments. We understand that emergencies do come up; however, we ask that you make every attempt to attend your scheduled appointment. If you cancel an appointment, we will not be able to hold your appointment time for the following week. If all appointments are full, you may need to wait until the following week to be scheduled. If you must call and cancel a scheduled appointment, there will be no charge IF we are able to schedule you for another AVAILABLE appointment time during the same week as the cancelled appointment. Otherwise, there will be a missed appointment fee. Two (2) "no-shows" for a scheduled appointment will result in a termination of services for three (3) months, **regardless of the reason**.

Please remember that payment is due at the time of service (this means when you check in). If you need to have your fee adjusted, please discuss this with your therapist. If you do not have payment at your scheduled appointment, you may carry a balance due for only one session. If you have more unpaid appointments than this, you will not be seen until your bill is up to date.

Thank you

I have read the above policy statement and have had my questions answered. I understand that my regular fee for therapy is $_____.

I understand that I will be charged $_____ if I miss an appointment or cancel without being able to reschedule within the same week. I understand that this fee will be assessed regardless of the circumstances.

I understand that payment is due at the time of service and that I will not be able to continue in therapy if I have a bill that totals more than one session. If I am having difficulty paying the therapy fee, I will let the therapist know as soon as possible and before accumulating a balance due so that we can discus lowering my fee.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

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TEEN INTAKE

Name _____ Date _____

School _____ Age _____

Are you living with someone other than your parents? _____

Foster parent/relative's name _____

Telephone number _____

CONCERNS (Please place a check mark next to issues you are concerned about.)

Suicide	Restlessness
Anger	Poor concentration
Physical violence	Memory problems
Dreams/nightmares	"Spacing out"
Anxiety	Sleep problems
Fearfulness	Sexual problems
Depression	Eating problems
Injury to self	Substance abuse
Recklessness	Other addictions
Relationship problems	Physical complaints
Lack of Trust	Chronic pain
Trust too much	Headaches
Loneliness	Flashbacks
Parenting	Children's behavior
Obsessive thoughts	Work problems

Other concerns:

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_____

Name

[Please try to complete as much of this form as possible. If questions are too difficult or you are not comfortable answering them yet, leave them blank. You may use the back of the page if necessary.]

Why are you seeking therapy at Rebuilding Hope, the Sexual Assault Center?

What are your goals for therapy?

Have you been in therapy before? Please list dates and names of therapists previously seen.

Please describe your strengths.

What coping skills do you use – what helps you get through stressful times? Include names of support systems and friends, ways of coping, etc.

Please describe your current problems:

Do you have children? If so, indicates names, ages and with whom they live.

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_____

Name

Please explain your school background (age started, academic record, last grade finished, special training, feelings about school, etc.)

What is your work history?

Have you ever been arrested or convicted? Please explain.

Have you had a problem with drugs or alcohol in past?

Would others be likely to say you have a problem with drugs or alcohol?

Have you ever received alcohol or drug treatment? If so, when and where?

If any of the answers to the drugs /alcohol questions were "yes", please indicate age at first use, substance of choice, amount generally used and frequency used.

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Name

Please describe any other addictions you might be concerned about, including comments about treatment.

Do you believe that your sexual behavior is safe and healthy? If no, explain. What about in the past?

Please describe your birth family – names, current ages and occupations and a two or three word description of each. If you grew up in a foster family(s) please comment on that history as well.

Who lives in your home? Same as above or different?

Is physical, sexual or emotional violence a problem in your home? If so, please describe.

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_____

Name

How would you describe your current home – the relationship, the strength, difficulties, activities, rules, conflicts, etc.?

Do you or a current member of your household have a history of sexual, physical or emotional violence? Please describe.

Describe significant events or traumas in your family life – moves, separations, deaths, victimizations, unemployment, divorce, arrests, etc.

Please describe drug and/or alcohol use in your home (by your parents or siblings):

Were other addictions present in your family?

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_____

Name

Did you experience other childhood traumas that you have been covered? Please explain.

Do you parents or siblings have a "psychological" (mental health) history or serious medical conditions? Explain.

Have you ever felt suicidal or made a suicide attempt? Please explain.

Do you engage in any form of self-harm? Have you in the past? If so, please explain.

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Therapy Services Client Initial Information Form

Client Name: _____
Address: _____
Phone Number: _____
Message Phone Number: _____
Date of Birth: _____
If client is a minor (14-18 y/o), can we discuss billing with their parent? Y N
Insurance: Y N

If yes, are they the primary policy holder? Y N
If no, name of Policy Holder? _____
Does client know if they have coverage? Y N
If client's insurance won't accept us, are they willing to still be seen on a sliding fee scale? If no, they can be taken off of list.

***With state insurance and CVC, client has to see someone who will accept their insurance first since CVC is a secondary payer**

☐ Medical Insurance Provider: _____
Policy Holder Name & DOB: _____
Policy Name: _____
ID #: _____
Group #: _____

☐ CVC Claim Number: _____

☐ For sliding scale consideration:
Gross monthly income for the family: $_____
Number of people dependent on this income: _____
Name of major income producer in the family: _____
Therapy cost, per session, is: $_____
"Missed appointment" including "no show" fee is: $_____
"Reschedule" fee if not rescheduled in the same week is: $_____

Therapy is weekly, are there any scheduling restrictions between M-F 6 AM – 7 PM?

_____

Additional comments/concerns: _____

_____

_____

The BDI-II contains 21 questions, each answer being scored on a scale value of 0 to 3. The cutoffs used differ from the original: 0–13: minimal depression; 14–19: mild depression; 20–28: moderate depression; and 29–63: severe depression. Higher total scores indicate more severe depressive symptoms.

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

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Orlando • Boston • New York • Chicago • San Francisco • Atlanta • Dallas
San Diego • Philadelphia • Austin • Fort Worth • Toronto • London • Sydney

Subtotal Page 1

Continued on Back

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

3 4 5 6 7 8 9 10 11 12 A B C D E

Subtotal Page 2

Subtotal Page 1

Total Score

PCL-5

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

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

REBUILDING HOPE! SEXUAL ASSAULT CENTER for PIERCE COUNTY

Therapy Services
Client Health Questionnaire

Name _____

Are you currently receiving medical care or treatment? YES [ ] NO [ ]

Your most recent doctor/clinic: _____

Date of most recent exam: _____

List illnesses/ surgeries / medical problems present during the last two (2) years:

List any known disabilities you have:

List known allergies and the type of reaction you experience:

List psychiatric medications:

Have you ever been hospitalized for psychiatric reasons? YES [ ] NO [ ] Explain:

Name of Hospital	Date	Reason for Hospitalization	Voluntary?
1.			
2.			
3.			

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Substance use:

Cigarettes _____ packs per day

Alcohol _____ drinks per day

Caffeine drinks _____ per day

Street Drugs: _____

Has substantially higher use/addiction, ever been true? YES [ ] NO [ ]
Have you ever experienced a head / brain injury? YES [ ] NO [ ]
If yes, please describe:

Describe the following:

Eating pattern:

Sleeping pattern:

Physical exercise:

Signature _____

Date _____

HOPE!

In an ongoing effort to better serve our clients, we are adding a few services to our Therapy Department. Please take a moment to complete the information below for our records. Thank you!

1. **Confirmation Calls**: We will make every attempt to contact you the day prior to your appointment date with a friendly reminder/confirmation call. Please indicate below the phone number you would prefer we use to reach you OR leave a message at confirming your appointment time.
   (_____) _____

2. **Survey**: You will be contacted approximately one month after your last appointment and/or contact here and asked to give us feedback on the service(s) you received through SACPC. Please be honest; information gathered will be used to further program development, modifications, and/or improvements.

   I prefer to participate in the survey process through:

   Email: _____

   Phone: (_____) _____

   Thank you!

   My signature indicates that I have read this forma and had my questions answered

   Client signature_____

   Date_____