HOPE! SEXUAL ASSAULT CENTER

# Therapy Services

## Policy and 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 focus on more long-term adjustment. We do not provide therapy treatment services to current staff, Board of Directors/Committee members, interns, volunteers, or their family members or close friends.

You have the right to be treated with dignity and respect, as well as 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 thirteen 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 or 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 13-17 year old children do need to sign a parental consent form. Regardless of parental consent, parents of clients age 13-17 may be notified if the client is indicating suicidal risk or serious suicidal 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 $140 charge per therapy session. If you are 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 by the state of Washington. All counseling staff are trained at the Master's level, receive regular supervision, and meet annual education requirements, or are Master's level interns in an accredited program. You will be provided with an individual disclosure form for your counselor that will explain their qualifications.

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 contact the state of Washington Department of Professional Licensing.

**Appointments**: Individual counseling sessions are usually 50 minutes long. The length of group sessions is 1-1 ½ hours. Individual and group counseling generally occur 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 that there may be a missed appointment fee if you cannot reschedule in the same week as the cancelled appointment with your therapist.

**Messages**: Messages may be left for therapists on their individual extensions at the Rebuilding Hope administrative office, phone number (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 at (253) 474-7273 or 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 Rebuilding Hope. Further, I know that Rebuilding Hope 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

_____

Date

_____

Witness

_____

Parent/Guardian Signature, if indicated

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# 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

REBUILDING HOPE! SEXUAL ASSAULT CENTER PIERCE COUNTY

Therapy Services
Financial Form

Date_____ Name_____

Address_____ City_____

Zip Code_____ Phone_____ Work Phone _____

Email Address_____

Gender_____ Date of Birth_____

Ethnicity/Race

*Asian Refugee_____ *Other Asian_____ *African American_____

*Caucsian _____ *Hispanic_____ *Native American_____

*Other Minority_____ *Multiracial_____ *Unkown_____

Name of School/Employer_____

Social Security Number_____

Do you have medical insurance? Yes [ ] No [ ]

If so, will it cover counseling? Yes [ ] No [ ]

Policy Name_____

ID Number_____

Group Number_____

Have you applied for Crime Victims Compensation? Yes [ ] No [ ]

CVC Number_____

Our standard fee for therapy is $140.00 per session. *If you are not able to pay the full fee, please discuss the sliding fee scale with your therapist.*

For sliding fee scale consideration, please complete the following:

Gross monthly income for the family $_____

Number of people dependent of this income_____

Name of major income producer in the family_____

According to your sliding scale fee, your therapy cost per session is $_____

Your missed appointment fee is $ _____

_____ _____

Client Signature Date

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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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.

Subtotal Page 2

Subtotal Page 1

Total Score

## PTSD Symptom Scale (PSS)

Name _____ Date _____ (Side One)

**Below is a list of traumatic events or situations. Please mark YES if you have experienced or witnessed the following events or mark NO if you have not had that experience.**

1. Serious accident, fire or explosion ☐ Yes ☐ No
2. Natural disaster (tornado, flood, hurricane, major earthquake) ☐ Yes ☐ No
3. Non-sexual assault by someone you know (physically attacked/injured) ☐ Yes ☐ No
4. Non-sexual assault by a stranger ☐ Yes ☐ No
5. Sexual assault by a family member or someone you know ☐ Yes ☐ No
6. Sexual assault by a stranger ☐ Yes ☐ No
7. Military combat or a war zone ☐ Yes ☐ No
8. Sexual contact before you were age 18 with someone who was 5 or more years older than you ☐ Yes ☐ No
9. Imprisonment ☐ Yes ☐ No
10. Torture ☐ Yes ☐ No
11. Life-threatening illness ☐ Yes ☐ No
12. Other traumatic event ☐ Yes ☐ No
13. If "other traumatic event" is checked YES above; please write what the event was _____
14. Of the question to which you answered YES, which was the worst _____
    (Please list the question #)
15. Which of the above incidences is the reason for which you are currently seeking treatment? _____
    (Please list the question #)

If you answered **NO** to all of the above questions, **STOP**
If you answered **YES** to any of the above questions, please complete the rest of the form

**Please check YES or NO regarding the event listed in question 15.**

Were you physically injured? ☐ Yes ☐ No

Was someone else physically injured? ☐ Yes ☐ No

Did you think your life was in danger? ☐ Yes ☐ No

Did you think someone else's life was in danger? ☐ Yes ☐ No

Did you feel helpless? ☐ Yes ☐ No

Did you feel terrified? ☐ Yes ☐ No

**Please complete both sides of this document if you answered YES to any of the first series of questions (1-14).**

## PTSD Symptom Scale (PSS)

(Side 2)

**Below is a list of problems that people sometimes have after experiencing a traumatic event. Please rate on a scale from 0-3 how much or how often these following things have occurred to you in the last two weeks:**

**0 Not at all**
**1 Once per week or less/ a little bit/ one in a while**
**2 2 to 4 times per week/ somewhat/ half the time**
**3 3 to 5 or more times per week/ very much/ almost always**

| | | | | | |
|---|---|---|---|---|---|
| 1. | Having upsetting thought or images about the traumatic event that come into your head when you did not want them to | 0 | 1 | 2 | 3 |
| 2. | Having bad dreams or nightmares about the traumatic event | 0 | 1 | 2 | 3 |
| 3. | Reliving the traumatic event (acting as if it were happening again) | 0 | 1 | 2 | 3 |
| 4. | Feeling emotionally upset when you are reminded of the traumatic event | 0 | 1 | 2 | 3 |
| 5. | Experiencing physical reactions when reminded of the traumatic event (sweating, increased heart rate) | 0 | 1 | 2 | 3 |
| 6. | Trying not to think or talk about the traumatic event | 0 | 1 | 2 | 3 |
| 7. | Trying to avoid activities or people that remind you of the traumatic event | 0 | 1 | 2 | 3 |
| 8. | Not being able to remember an important part of the traumatic event | 0 | 1 | 2 | 3 |
| 9. | Having much less interest or participating much less often in important activities | 0 | 1 | 2 | 3 |
| 10. | Feeling distant or cut off from the people around you | 0 | 1 | 2 | 3 |
| 11. | Feeling emotionally numb (unable to cry or have loving feelings) | 0 | 1 | 2 | 3 |
| 12. | Feeling as if your future hopes or plans will not come true | 0 | 1 | 2 | 3 |
| 13. | Having trouble falling or staying asleep | 0 | 1 | 2 | 3 |
| 14. | Feeling irritable or having fits of anger | 0 | 1 | 2 | 3 |
| 15. | Having trouble concentrating | 0 | 1 | 2 | 3 |
| 16. | Being overly alert | 0 | 1 | 2 | 3 |
| 17. | Being jumpy or easily startled | 0 | 1 | 2 | 3 |

**Please mark YES or NO if the problems above interfered with the following:**

| | | | | | |
|---|---|---|---|---|---|
| 1. | Work | ☐ Yes ☐ No | 6. | Family relationships | ☐ Yes ☐ No |
| 2. | Household duties | ☐ Yes ☐ No | 7. | Sex life | ☐ Yes ☐ No |
| 3. | Friendships | ☐ Yes ☐ No | 8. | General life satisfaction | ☐ Yes ☐ No |
| 4. | Fun/leisure activities | ☐ Yes ☐ No | 9. | Overall functioning | ☐ Yes ☐ No |
| 5. | Schoolwork | ☐ Yes ☐ No | | | |

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# Adult Intake

Name_____ Date_____

Age_____ Date of Birth_____

[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.]

Briefly Comment on your school and/or work history:

Have you ever been arrested or convicted? Please explain:

Please briefly describe any past or current drug or alcohol use:

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

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

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Name_____

Please list current family members and/or significant others:

| Name | Age | Relationship | Where do they live? |
|---|---|---|---|

Please describe the family in which you grew up:

| Name | Age | Relationship | Where do they live? |
|---|---|---|---|

Please describe drug, alcohol, or other addictions present in your birth family:

Please briefly describe any past or current sexual, physical, or emotional abuse/assaults:

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Name_____

Please list any additional losses or traumatic events in your life:

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

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

Please list any other agencies or individuals providing services to you:

Name_____

CONCERNS (Please place a check mark net 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:

Why are you seeking therapy at Rebuilding Hope, The Sexual Assault Center for Pierce County?

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 and/or coping skills:

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**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 illness/surgeries/medical problems present within the last two (2) years:

List any known disabilities that you have:

List any known allergies and the type of reaction that you experience:

List psychiatric medications:

Have you ever been hospitalized for psychiatric reasons? Yes [ ] No [ ]

If yes, 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 occurred? Yes [ ] No [ ]

Have you ever experienced a head or brain injury? Yes [ ] No [ ]

If yes, please describe:

Describe the following:

Eating pattern:

Sleeping pattern:

Physical exercise:

Signature_____

Date_____

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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_____