HIPAA Notice of Privacy Practices

Effective as of March/1/2022

Reflections Counseling of Denton, PLLC
1306 N Locust St., Denton, Texas 76201
940-367-9887

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations, except SUD records as explained in Feb 15, 2026 addendum, without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

You have the right to Choose someone to act for you: - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Required Addendum to our NPP (Notice of Privacy Practices)

Effective as of February15,2026

Reflections Counseling of Denton, PLLC
1306 N Locust St., Denton, Texas 76201
940-367-9887

Special Privacy Protections for Certain Health Information

We are **not primarily a substance use disorder (SUD) treatment program. We may receive and maintain SUD-related information incidentally** (e.g., referrals, history, meds, labs) and that information we maintain may be subject to additional federal privacy protections, including records related to the diagnosis, treatment, or referral for treatment of a substance use disorder. These records are protected by federal law (42 C.F.R. Part 2), which, in some cases, is more restrictive than HIPAA. When these stricter rules apply, we follow them.

How We May Use and Disclose Health Information

We may use and disclose your health information for treatment, payment, and health care operations. When information includes substance use disorder records, additional legal requirements may apply, including your written consent before using or disclosing that information.

Limits on Use of Substance Use Disorder Records

Federal law places **strict limits** on how substance use disorder records may be used or disclosed. Substance use disorder records cannot be used or disclosed to initiate or substantiate civil, criminal, administrative, or legislative proceedings without written consent or a qualifying court order.

Authorization and Consent

Certain uses and disclosures require written authorization. You may revoke authorization at any time by written reques, except where already relied upon. If your health information includes substance use disorder records, your authorization may allow us to use and disclose that information for **treatment, payment, and health care operations**, as permitted by law.

Your Rights Regarding Your Health Information

You have rights to inspect, access, amend, request restrictions, request confidential communications, and receive an accounting of disclosures, as permitted by law.

Redisclosure Notice

If your health information is disclosed to another party, that party may be permitted to **redisclose** the information, and it may no longer be protected by HIPAA. However, **substance use disorder records** may continue to be protected by federal law even after disclosure, depending on the circumstances.

Public Health and De-Identified Information

We may disclose **de-identified health information** for public health, research, or health care operations purposes as permitted by law. De-identified information does not identify you and cannot reasonably be used to identify you.

Fundraising Communications

We may contact you for **fundraising purposes**. You have the right to **opt out** of receiving fundraising communications at any time. Your decision to opt out will **not affect your access to care**.

Complaints and Enforcement

If you believe your privacy rights have been violated, you may file a complaint with us or with the **U.S. Department of Health and Human Services**. You will not be retaliated against for filing a complaint.

Changes to This Notice

We reserve the right to change this Notice of Privacy Practices at any time. Any changes will apply to all health information we maintain. The current version of this Notice will be available upon request and on our website.

Reflections Counseling of Denton
1306 N. Locust Street, Denton, Texas 76201
(940) 367-9887

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Reflections Counseling of Denton's Notice of Privacy Practices. By signing below, I am *only* giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Print Client Name	Client Signature	Date

Reflections Counseling of Denton
1306 N. Locust Street, Denton, TX 76201

Phone: 940-367-9887 Fax: 940-243-0398

Client Consent to Treatment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected healthcare information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Print Client Name	Client Signature	Date

Dennise Brosig M.S., Licensed Professional Counselor Associate
Supervised by Heather N. Smith, M.Ed., Licensed Professional Counselor Supervisor
Reflections Counseling of Denton
1306 N. Locust Street, Denton, TX 76201
940-367-9887

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications: In May 2020, I obtained a Bachelor of Arts degree in Psychology with a minor in Behavior Analysis and Drug Abuse and Addiction from the University of North Texas. I completed my graduate studies with a Master of Science in Counseling and Human Development from the Texas Woman's University in December of 2022. My graduate program is accredited by the American Counseling Association's Council for the Accreditation of Counseling and Related Educational Programs (CACREP), which is the nationally recognized accrediting agency for counseling graduate programs

I am currently a Licensed Professional Counselor Associate in the state of Texas, under the supervision of Heather N. Smith, M.Ed., LPC-S, License #63750. In accordance with the state laws of Texas, I hold a license as a Licensed Professional Counselor Associate, License #91790. Counselors wishing to practice must maintain mandatory credential checks with state agencies that grant licenses and regulate professional behavior.

Experience: During my master's program at the Texas Woman's University, I completed a practicum and internship. During my internship at the Texas Woman's University Counseling and Family Therapy Clinic I worked with adults, children, and adolescents. I also facilitated grief groups for Journey of Hope for children and adolescents.

Nature of Counseling: I primarily pull from the Cognitive Behavioral Theory (CBT) while counseling. When using CBT we will be able to collaborate on your therapeutic goals and find solutions that best fit your unique needs. CBT allows you to reflect on the core of your concerns while simultaneously work to challenge any maladaptive behaviors those core beliefs have enabled. It is important to remember that counseling is a tool to help individuals gain insight into their own hardships and provide them the tools to best overcome them. Counseling can also look different for everyone, while some might benefit from a few sessions, others might require extensive counseling. Keep in mind that the journey to healing is a unique process and I will do my best to accommodate your individual needs.

Conditions of Counseling

Court: I do not agree to serve as an expert witness or to provide testimonial services for you and you agree not to cause me to be used in this way. Should you or your attorney subpoena me as a factual case witness or involve me in court-related proceedings, you agree to pay Reflections Counseling of Denton $200 for every hour of my time involved including case preparation, phone calls with attorneys, travel and witness time. You further agree to pay a retainer fee of $1000.00 at the time a subpoena is served, to be applied toward these charges. If a subpoena is issued for me it will be turned over to my attorney and I will consult with that attorney as necessary. A bill will be rendered to you for immediate payment when a subpoena is issued. Please let me know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motives.

Counseling Relationship: Unless you prefer otherwise, I will call you by your first name. Please call me Dennise. During the time you and I work together, we usually will meet weekly for approximately 45-minute sessions. Although our sessions may be psychologically deep, ours is a professional relationship rather than a social one. Therefore, please do not invite me to social events, bring me gifts, ask to barter or exchange services, ask me to write references for you, or ask me to relate to you in any way other than the professional

context of our counseling relationship. You will benefit the most if our interactions address your concerns exclusively.

I conduct all counseling sessions in English or with a translator for whom you arrange and pay. I do not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation. If significant differences, such as in culture or belief system, exist between us, I will work to understand those differences.

Effects of Counseling: At any time, you may initiate with me a discussion of possible positive or negative effects of entering or not entering into, continuing, or discontinuing counseling. I expect you to benefit from counseling. However, I cannot guarantee any specific results. Counseling is a personal exploration that may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. You may feel troubled, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. In addition, counseling can, at times, result in long lasting effects. For example, one risk of couple counseling is the possibility that the marriage may end. Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions, whereas others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. If you choose to end the counseling relationship, I ask that you participate in a termination session. You also have the right to refuse or to discuss modification of any of my counseling techniques or suggestions that you believe might be harmful. I render counseling services in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Boards of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time for any reason you are dissatisfied with my services, please let me know so that existing issues can be worked through. If after speaking with me your concerns still persist, you may report your complaints to the Texas Board of Examiners of Licensed Professional Counselors.

Emergencies: Telephone conversations cannot adequately substitute for therapy sessions. Phone calls are intended for emergencies or scheduling appointments. There is no charge for calls which last less than ten minutes during normal business hours. After hour calls and calls lasting more than ten minutes are billed at $1 per minute. In the event you are having a crisis and are unable to reach me, you should go to your nearest hospital emergency room.

Independent Contractors: Each client within Reflections Counseling of Denton is under the care of a counselor. Counselors are not employees of Reflections Counseling of Denton, and therefore, are independent contractors. Counselors assume responsibility for the mental health care they provide.

Confidentiality: All of our communication becomes part of the clinical record, which may be accessible to you upon written request. I will keep confidential anything you say to me, with the following exceptions: a) you direct me to release your records; b) I determine that you are a danger to yourself or someone else including you potentially infecting someone else with a life-threatening illness; c) you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person; d) you disclose having been sexually abused as a child and disclose the offenders name and/or relationship to you; e) you disclose sexual contact with a mental health professional with whom you had a professional therapeutic relationship; f) I am ordered by a court to disclose information; or e) threats to national security.

As part of Reflections Counseling of Denton, I meet with the other professionals of this office on a weekly basis for case management. During this time, I may talk about your treatment to gain feedback on different approaches and/or techniques that could be beneficial in use during your sessions.

Modern means of communication including cell phone and email, have inherit limitations to privacy. Reflections Counseling of Denton counselors use business cell phones. Your signature below indicates you have been informed, understand, and accept the limitations should you communicate with me or my associates through these mediums.

I may present programs at professional conferences and/or publish in professional publications on the topic of counseling. In this case, I may refer to my experiences as a counselor. If I make reference to my counseling with you, I will do so in a way that disguises your identity. If I cannot make such a reference without revealing your identity, I will ask you to sign a waiver. If you do not agree to sign, I will not make identifiable reference to you. You are not required to waive your right to confidentiality at any time.

Further information about confidentiality is addressed in the Notice of Privacy Practice and Informed Consent.

In the event that I believe you are in danger, physically or emotionally, to yourself or another person, you specifically consent for me to warn the person in danger and to contact the following persons, in addition to medical and/or law enforcement personnel:

Name	Relationship	Telephone Number

Records: Records are kept of all of our communications, including contact via phone and email, and are maintained in the form of paper and electronic files. Your record is my property and will be stored for five years after your file is closed. Records for minor clients are destroyed five years after the client turns 18 years of age.

Conditions of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, I am ethically and legally required to request you to sign a release so I may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. This practice ensures continuity of care so that I may provide you with the best treatment possible.

Referrals: I recognize that not all conditions presented by clients are appropriate for treatment at this office. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal and written exploration of alternatives to counseling will be made available upon request. You will be responsible for contacting and evaluating those referrals and/or any other alternatives.

Affirmation: By your signature below, you are indicating that you read and understood this statement, that any questions you had about this statement were answered to your satisfaction, and that you were furnished a copy of this statement. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Client's Signature	Date
Counselor's Signature	Date

Reflections Counseling of Denton
Dennise Brosig, M.S., LPC Associate
Under the supervision of Heather Smith, M.Ed., LPC-S
(940) 367-9887

Counseling Policies

Please Initial Each Item:

_____ I understand that Dennise Brosig, M.S., LPC Associate is an independent licensed professional counselor intern whom shares office space with other independent counselors through Reflections Counseling of Denton.

_____ I understand that Ms. Brosig is does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to the nearest emergency room for assistance.

_____ I understand that Ms. Brosig reserves the right to increase her fees for services at any time. In the event that a decision to do so is made, I understand that a notice will be posted at the front desk one month prior to the new charges taking effect.

_____ I understand that if a phone consultation lasting over 10 minutes is necessary I will be billed $1 per minute. I also understand that this fee will be due prior to my next session with Ms. Brosig.

_____ I understand and agree to pay for any appointments I fail to attend or cancel without 48 hour notice. Furthermore, I understand that if I reschedule an appointment within the same week without 48 hour notice, I will be need to pay an administration fee of $25.

_____ I understand that if a check is returned, a processing fee of $35 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $35 processing fee. After a returned check, Reflections Counseling of Denton may require credit card or cash payment for future appointments.

_____ I understand that Ms. Brosig is not an expert witness nor does she provide testimonial services.

_____ I understand that should I cause Ms. Brosig to be subpoenaed as a factual case witness or involve her in court-related processes, I will be required to pay a retainer fee of $1000, with a charge of $200 every hour she is involved in the case preparation, phone calls, travel, and witness time, etc.

_____ I understand that if I do Ms. Brosig a subpoena that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.

Client Affirmation:

Sign _____ Date _____

Reflections Counseling of Denton

"Compassionate, Unbiased Care"

Appointment Reminder By Email

We will send you an appointment reminder by email. The appointment reminder will include only the date and time of your appointment and your service provider name. We will not encrypt the message. Health care information sent by regular email could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email please write your email below:

_____

Email

By signing below you accept responsibility for the risks associated with email and will not hold us responsible for any event that occurs after we send the message. You also acknowledge that it is your responsibility to attend appointments regardless if you receive a reminder email or not.

_____

Print Name

_____ _____

Signature Date

Reflections Counseling of Denton
1306 N. Locust Street
Denton, Texas 76201
Phone: (940) 367-9887 Fax: (940) 243-0398

Credit Card Authorization Form

I, _____, hereby authorize Reflections Counseling of Denton to use
(cardholder name)
the following credit card information as payment on behalf of _____.
(client name)

Agree to and initial **one** of the following:

_____ Reflections Counseling of Denton may charge this card for appointments held, same-day cancellations, and no-shows.

_____ Reflections Counseling of Denton may *only* charge this card in the event of a same-day cancellation or no-show. Another form of payment will be used for appointments held.

Credit Card Information:

Credit card #: _____

Expiration Date: _____ (mm/yy) Card Security Code: _____

Type of card: VISA MASTERCARD AMERICAN EXPRESS DISCOVER
(circle one)

Credit card statement address:

_____

_____

_____

_____ _____
Cardholder Signature Date

Please note: If your card is declined we will make an attempt to contact you to receive payment with another method. If we are unable to contact you, we will run the card on file once a week until approved.

Reflections Counseling of Denton
1306 N. Locust Street, Denton, Texas 76201
Phone: (940) 367-9887 **Fax: (940) 243-0398**

New Client Information

Client's Name _____

Address _____ City _____ State _____ Zip _____

By entering your telephone contact information below, you give permission for your counselor's office personnel to leave messages on your home answering machine and/or cell phone in regards to your appointments and billing balances. You also acknowledge that you understand you may not be the only person to hear said messages.

Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____) _____ Fax (____) _____

Birth Date _____ SS# _____

Check appropriate box:

❑ Male ❑ Female

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

❑ Employed ❑ Unemployed ❑ Retired ❑ Full-time student ❑ Part-time student

Client's Employer _____ Work Phone (____) _____

Business Address _____ City _____ State _____ Zip _____

If patient is a student, name of school/college _____

How did you learn about Reflections Counseling of Denton?

❑ Reflections Counseling of Denton website ❑ Google ❑ Psychology Today ❑ Internet search

❑ Referred by_____ ❑ Other _____

Emergency Contact Information

Person to contact in case of emergency _____

Relationship to client _____ Phone (____) _____

Signature of client _____ Date _____

General Health Questionnaire

Reflections Counseling of Denton * 1306 N. Locust Street * Denton, Texas 76201

Phone: 940-367-9887 Fax: 940-243-0398

Patient Name: _____ Age: _____

Please complete the following. You may use an additional sheet if more space is needed.

Please note: Your answers will remain completely confidential; it is very important that you answer these questions honestly.

Social History/Habits

Smoke Cigarettes	Packs/day: Years smoking:	Consume Alcoholic Beverages	Drinks/week:
Consume caffeinated beverages	Drinks /day:	Recreational Drugs	Types and times/week:
Exercise	Hours/week:		

Operations/Hospitalization

Year	Operation	Year	Hospitalization

Current Medications

(Please include any birth control or hormone therapy)

Medications	Prescribing Physician	Medications	Prescribing Physician

Please continue on the next page.

Any Known Drug Allergies:

_____

Any Over-the-counter medications:

_____

Current Therapist (if you do not have a therapist, please print none):

_____

If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and indicate the name of the physician treating you. You may use an additional sheet of paper if more space is needed.

Illness or Medical Problem	Physician Treating you

Illnesses or Medical Problems

Please check the corresponding box for the following medical problems you have or have had in the past.

- ❒ AIDS/Positive HIV
- ❒ Allergies
- ❒ Anemia
- ❒ Asthma
- ❒ Bleeding Disorder
- ❒ Convulsions/Seizures
- ❒ Eating Disorder
- ❒ Hepatitis
- ❒ High Cholesterol
- ❒ Mental Illness
- ❒ Sexually Transmitted Disease
- ❒ Stomach Ulcers
- ❒ Thyroid Problem
- ❒ Tuberculosis
- ❒ Cancer/Tumor
- ❒ Diabetes
- ❒ Heart Disease
- ❒ High Blood Pressure
- ❒ Kidney/Bladder Disease
- ❒ Migraine Headaches

Please continue on the next page.

Please check the corresponding box for the following symptoms you felt within the past 6 months.

- ❒ Abdominal Discomfort
- ❒ Difficulty swallowing
- ❒ Dry mouth
- ❒ Rapid Heartbeat (palpitations)
- ❒ Tightness/pain in chest
- ❒ Shortness of breathe
- ❒ Dizziness
- ❒ Noticeable changes in sleep patterns
- ❒ Irritability/anger
- ❒ Increasing drug/alcohol use
- ❒ Abnormal eating patterns
- ❒ Feeling out of control
- ❒ Prolonged sadness/ unexplained crying
- ❒ Significant changes in appetite/weight
- ❒ Pessimism
- ❒ Loss of energy
- ❒ Feelings of guilt/worthlessness
- ❒ Inability to concentrate/indecisive
- ❒ Inability to take pleasure in former interests
- ❒ Social withdrawal
- ❒ Numbness in the legs and feet
- ❒ Recurring thoughts of death/suicide
- ❒ Inability to relax, constant worrying
- ❒ Rapid Thoughts

Please check the corresponding box for the following information on your sexual history.

- ❒ Sexually Transmitted Disease
- ❒ Sexual difficulty
- ❒ Condom use: Yes: ____ No: ____
- ❒ Other birth control:_____

For female patients:

- ❒ Problems with menstrual periods
- ❒ Last menstrual period date: _____
- ❒ Pregnancy, number: _____
- ❒ Miscarriages, number: _____
- ❒Abortions, number: _____

Patient Signature: _____Date: _____

Signature of patient or legal representative

Relationship: _____

Legal representative's relationship to the patient

Your Personal
Mental Health Profile

Instructions:

Please print out this form and check the appropriate box for each question. If you have concerns about your mental health, please share your completed Mood Disorder Questionnaire, Family Mental Health History Questionnaire and this questionnaire with your doctor. An accurate diagnosis can only be made by your doctor, after a comprehensive mental health screening.

This questionnaire is not meant to be a diagnostic tool nor is it meant to take the place of an evaluation by a physician or other mental health professional.

1. Have you suffered from depression, anxiety, or mood swings? **Yes ❑ No ❑**

2. Have you taken antidepressant or antianxiety medications for these symptoms and found them to be ineffective or only somewhat effective?

   Yes ❑ No ❑

3. Your doctor may find it helpful to see a list of these medications. To help your doctor, take a few moments to write down a brief medication history for symptoms you experience, such as anxiety, depression, mood swings, irritability, and/or poor sleep. You may find it convenient to print out this form and use it to fill in your information, using additional pieces of paper if necessary.

   My Medication Experience

   My Doctor says condition is called: _____

Symptom	How long I've been Experiencing it	Medication(s) – and Dosage(s) – I'm taking for it	Results: is the Symptom Relieved Fully, Partially, Or not at all?

Family Mental Health History

Instructions: For each question, please circle the appropriate answer. If you do not know the answer, please circle "unknown" or "not applicable".
This questionnaire is not meant to be a diagnostic tool nor is it meant to take the place of an evaluation by a physician or other mental health professional. Only a doctor can make an accurate diagnosis after a comprehensive mental health screening.

1. Is there a history of "nervous breakdown," anxiety, or other mental illness in the *following biological family* members:

Mother:	Yes	No	Unknown	
Father:	Yes	No	Unknown	
Sibling (brother/sister)	Yes	No	Unknown	Not Applicable
Children (son/daughter)	Yes	No	Unknown	Not Applicable

2. Is there a history of Bipolar I Disorder or Bipolar II Disorder in the following biological family members:

Mother:	Yes	No	Unknown	
Father:	Yes	No	Unknown	
Sibling (brother/sister)	Yes	No	Unknown	Not Applicable
Children (son/daughter)	Yes	No	Unknown	Not Applicable

3. Is there a history of major depression in the following *biological* family members:

Mother:	Yes	No	Unknown	
Father:	Yes	No	Unknown	
Sibling (brother/sister)	Yes	No	Unknown	Not Applicable
Children (son/daughter)	Yes	No	Unknown	Not Applicable

4. Is there a history of psychosis in the following biological family members:

Mother:	Yes	No	Unknown	
Father:	Yes	No	Unknown	
Sibling (brother/sister)	Yes	No	Unknown	Not Applicable
Children (son/daughter)	Yes	No	Unknown	Not Applicable

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1		
2. Feeling down, depressed, or hopeless	0	1		
3. Trouble falling or staying asleep, or sleeping too much	0	1		
4. Feeling tired or having little energy	0	1		
5. Poor appetite or overeating	0	1		
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1		
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1		
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		
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0			

Add columns: _____ + _____ + _____

10. 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 along with other people?	Not difficult at all _____ Somewhat difficult _____ Very Difficult _____ Extremely Difficult _____

ZT274388

Social Phobia Inventory

Initials _____Age _____Sex _____Date _____ID#_____

Please check how much the following problems have bothered you during the past week. Mark only one box for each problem, and be sure to answer all items.

	Not at all	A little bit	Somewhat	Very much	Extremely
1. I am afraid of people in authority.	0	1	2	3	4
2. I am bothered by blushing in front of people.	0	1	2	3	4
3. Parties and social events scare me.	0	1	2	3	4
4. I avoid talking to people I don't know.	0	1	2	3	4
5. Being criticized scares me a lot.	0	1	2	3	4
6. Fear of embarrassment causes me to avoid doing things or speaking to people.	0	1	2	3	4
7. Sweating in front of people causes me distress.	0	1	2	3	4
8. I avoid going to parties.	0	1	2	3	4
9. I avoid activities in which I am the center of attention.	0	1	2	3	4
10. Talking to strangers scares me.	0	1	2	3	4
11. I avoid having to give speeches.	0	1	2	3	4
12. I would do anything to avoid being criticized.	0	1	2	3	4
13. Heart palpitations bother me when I am around people.	0	1	2	3	4
14. I am afraid of doing things when people might be watching.	0	1	2	3	4
15. Being embarrassed or looking stupid are my worst fears.	0	1	2	3	4
16. I avoid speaking to anyone in authority.	0	1	2	3	4
17. Trembling or shaking in front of others is distressing to me.	0	1	2	3	4

From Connor K., Davidson J., Churchill L., Sherwood A., Foa E., Weisler R., "Psychometric properties of the Social Phobia Inventory". Br J Psychiatry.2000: 176:379-86.

Bipolar Spectrum Diagnostic Scale (BSDS)

Instructions: Please read through the entire passage below before filling in any blanks.

Some individuals notice that their mood and/or energy levels shift drastically from time to time _____These individuals notice that, at times, their mood and/or energy level is low, and at other times, very high _____ During their "low" phases, these individuals often feel a lack of energy, a need to stay in bed or get extra sleep, and little or no motivation to do things they need to do _____ They often put on weight during these periods _____ During their low phases, these individuals often feel "blue," sad all the time, or depressed _____ Sometimes, during these low phases, they feel hopeless or even suicidal _____ Their ability to function at work or socially is impaired _____ Typically, these low phases last for a few weeks, but sometimes they last only a few days _____ Individuals with this type of pattern may experience a period of "normal" mood in between mood swings, Their mood and energy level feels "right" and their ability to function is not disturbed _____ They may then notice a marked shift or "switch" in the way they feel _____ Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do _____ Sometimes, during these "high" periods, these individuals feel as if they have too much energy or feel "hyper" _____ Some individuals, during these high periods, may feel irritable, "on edge," or aggressive _____ Some individuals, during these high periods, take on too many activities at once _____ During these high periods, some individuals may spend money in ways that cause them trouble _____ They may be more talkative, outgoing, or sexual during these periods _____ Sometimes, their behavior during these high periods seems strange or annoying to others _____ Sometimes, these individuals get into difficulty with co-workers or the police during these high periods _____ Sometimes, they increase their alcohol or non-prescription drug use during these high periods _____

Now that you have read the passage, please check one of the following four.

____ This story fits me very well or almost perfectly
____ This story fits me to some degree but not in most aspects
____ This story fits me fairly well
____ This story doesn't really describe me at all

Now, please go back and put a check after each sentence that definitely describes you.

Standard Alcohol Screening

Reflections Counseling of Denton * 1306 N. Locust Street * Denton, Texas 76201
Phone Number: 940-367-9887 Fax Number: 940-243-0398

Patient Name: _____ Date: _____

Note: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that you answer these questions honestly; your answers will remain confidential. Please refer to reverse side of paper for standard drinking chart.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect standard drink sizes in the United States, the number of drinks in question 3 was change from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org