PERFORMANCE INSIGHT – Dr. Scott A. Dreyer
POLICIES AND PROCEDURES

Welcome to Performance Insight, a psychological services practice specializing in helping individuals attain their personal, relational, business, and performance related goals. Dr. Dreyer is an independent practicing licensed clinical psychologist. Dr. Scott A. Dreyer, will be solely responsible for your professional services. Dr. Dreyer is an independent provider and has no legal or professional association with the practitioners from the Mathis Ferry Professional Building or Charlestowne Counseling Associates.

This document contains important information about the professional services and business policies at Performance Insight. The information will introduce the policies and procedures of our practice and will serve as your treatment contract. Please read it carefully and I will be happy to discuss any questions you may have at our next meeting. When you sign this document, it will represent an agreement between us.

CLINICAL SERVICES

The initial sessions will involve an evaluation of your needs. By the end of the evaluation, I will offer you initial impressions of what our work together will include. We will also develop an initial treatment plan, if you decide to continue. You should evaluate this information along with your opinions of whether you feel comfortable working with me. Psychotherapy/Personal Consultation involves a commitment of time, money, and energy, so you should be confident about the psychologist you select. Trust is most important in our relationship. If you have questions about my services, credentials or procedures, we should discuss them whenever they arise. If necessary, I will be happy to help you obtain an appropriate referral to another mental health professional.

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead it calls for **an active effort** on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy has both benefits and risks. As psychotherapy often requires recalling unpleasant aspects of your history, common risks may include experiencing uncomfortable feelings such as anger, sadness, anxiety, or guilt. As your psychologist and personal consultant, I will do my best to help you negotiate these experiences. Psychotherapy and psychological treatment has been researched, documented and proven to produce significant positive changes for those who undertake such services. Benefits include a significant decrease of negative feelings/emotions/thoughts, improved relationships, resolution of specific problems, and increased life satisfaction.

APPOINTMENTS

I normally conduct an evaluation that will last from 1-2 sessions. During this time we can both decide if I am the best person to provide services you need to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-50 minute session per week at a time we agree on, although some sessions may be longer or more frequent. Depending on severity, frequency of sessions might be shorter or duration between meetings might be longer. As treatment goals are met, sessions will typically decrease in frequency. Decisions to reduce the frequency of sessions will be based upon both your comfort level and my professional guidance.

We at Performance Insight appreciate the need to be as prompt and reliable in keeping scheduled appointments and will request the same from you. If, however, you are unable to keep a scheduled appointment we request that you give at least 24 hours advanced notice of cancellation. **Once an appointment hour is scheduled, you will be expected to pay for it in entirety unless you provide 24 hours advanced notice of cancellation OR unless we both agree that you were unable to attend due to circumstances beyond your control. Canceling a session within 24-hours of the scheduled appointment will result in a financial payment equal to half the amount of a typical 50 minute session payment . It is important to**

note that insurance companies do not provide reimbursement for no-show or cancelled sessions. On rare occasions, it may be necessary for us to cancel an appointment with you. In the event that this occurs we will make every effort to give you as much advanced notice as possible. Dr.Dreyer holds himself accountable to the same no-show and late cancelation fees described above. Emergency situations will be considered on an individual basis.

PROFESSIONAL FEES

The fee for the initial 75-90 minute consultation/evaluation at Performance Insight is $. The hourly fee for subsequent (45-50 minute) meetings is $_ . In addition to

regularly scheduled appointments in our office, we charge this hourly amount for other professional services that you may want or need including report writing, telephone conversations & e-mail exchanges beyond 10 minutes of duration, attendance at other meetings with other professionals that you have authorized, preparation of records and treatment summaries and other miscellaneous services. Any services provided for less than or more than an hour will be pro-rated in fifteen-minute increments based on the hourly rate above. Complimentary telephone/e-mail consultation is available on a limited basis (limitations can be discussed at our next meeting). You should be aware that telephone and e-mail consultation and information discussed through such means is not guaranteed to be confidential. All efforts will be made to protect such consultations and information. Telephone/e-mail conversations lasting longer than 5-10 minutes will be billed at fifteen-minute increments based on the standard hourly rate.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify to another party. Because of the additional time & energy involved in legal proceedings, I charge $400.00 per hour for preparation, time away from my office and attendance at any legal proceeding. In addition, if I am conducting on-site legal services, I charge $250.00 per hour. You will be expected to pay for each session at the time it is held unless we agree otherwise or unless other arrangements have been made in advance. Cash and checks are accepted. Speak with Dr. Dreyer about credit card options.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If I am accepting credit cards at the time of your service, I prefer that you have a credit card on file to pay unpaid fees.

If your account has not been paid for more than 60 days and arrangements for payments have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out billing forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled. **It is important for you to know that ultimately you (not your insurance company) are responsible for full payment of my fees.** I do not file secondary insurances. You may send a billing form and the explanation of benefits you receive from your primary insurance to your secondary insurance in order to file the claim yourself. It is very important that you find out exactly what mental health services your insurance policy covers.

Please carefully read the section of your insurance booklet that describes mental health services. If you have questions about coverage, call your administrator. Dr. Dreyer will also be able to guide you in the process of accessing out-of-network benefits. Please see our Insurance Worksheet or view it on our website www.performanceinsight.com

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before providing reimbursement for services. These plans are often limited to short-term treatment approaches designed to address specific problems that interfere with a person's usual levels of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. It may be necessary to seek approval for more sessions after you exceed a certain number of sessions.

Please be aware that most insurance companies require you to authorize me to provide them with a clinical psychiatric diagnosis. Sometimes, I have to provide additional clinical information such as treatment plans, summaries, or copies of the entire record (very rare). This information will become a part of the insurance company files and part of the managed care company that

regulates your insurance. Performance Insight cannot be held responsible for the confidentiality of information that an insurance company or managed care company has access to. In some cases, they may share the information with a national information medical information bank. Performance Insight, LLC does not have control over how they might use the information.

**It is important to remember that you always have the right to pay for my services yourself (out-of-pocket) if you do not wish to share such information with your insurance entities and want to avoid the problems described above. Those clients that pay out-of-pocket have their records completely protected. Information does not leave the locked cabinets of the office.

CONTACTING US

You can contact me by telephone at (843) 367-1014 or by e-mail at drdreyer@performanceinsight.com. I may not be immediately available by telephone or I may not be in the office at the time you call. If I am in the office I may be meeting with another client. When I am unavailable, I invite you to leave a message on my individual voice mail/e-mail services. This messaging system is designed to be as secure as possible. Only I have password access to my voice messaging system. Only I have password protected access to the email account drdreyer@performanceinsight.com. I will make every effort to return your call/ e-mail as soon as feasibly possible.

EMERGENCIES

In the event that you are experiencing a personal emergency or crisis and feel you need to speak with somebody right away, you should attempt to contact me. If I am unavailable or you need assistance during off-hours, contact a family member, your family physician, the local emergency room (request to speak with the psychologist/psychiatrist on call – ex. Palmetto Hospital (747-5830), hotline (211) or mobile crisis (727-2086). If I am unavailable for an extended period of time, I will provide you with the name of a colleague to contact if necessary.

PROFESSIONAL RECORDS

I am required to keep and protect treatment records. With the exception of your permission, all records are secured, locked and kept confidential. You have the right to review your records or obtain them. However, I highly recommend that you review the records with me directly so that we may discuss the contents.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving them any information, I will discuss the matter with you and develop an appropriate method of communication.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist are protected by South Carolina law and the ethical code of the American Psychological Association. Because of this, we can only release information about our work to others with your written permission. This will be done in the form of a written release, which I will carefully explain to you. There are some situations in which we are legally obligated break confidentiality. These situations include:

- If we believe that a child/elderly person/disabled person is being abused, we may be required to report this to the appropriate state agency.
- If we believe that a client is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- If a client threatens harm to himself/herself, we are obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- If a client's records are subpoenaed by the court, we may be obligation to comply with the subpoena.
- If a government agency is requesting the information for health oversight activities, required to provide it to them.
- If a patient files a complaint or lawsuit against us, I may disclose relevant information regarding that patient in order to defend myself.
- If I am treating a patient who files a workers' compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to the patient's employer, the insurer, or the Workers' Compensation Commission.

My signature below indicates that I have read and understand the terms of treatment. I acknowledge that I have had ample opportunity to clarify any concerns I may have and agree to treatment under the above mentioned conditions.

Client/Guardian Signature Date

Witness Signature Date
PERFORMANCE INSIGHT, LLC / SCOTT DREYER, Psy.D.

CREDIT CARD AUTHORIZATION FORM

I have found that it is easier to pay for my services by credit/debit card – that way, I can simply take care of the payment at the end of our session. This allows clients to earn points/miles on their card, prevents the accumulation of high outstanding balances, reduces the likelihood of bounced checks and reduces the likelihood of financial issues interfering with the therapeutic relationship/treatment Please complete this form, or talk to Dr. Dreyer if you'd like to use another method of payment. Checks and cash are also accepted and welcomed.*

Please charge the following to my credit card: (circle any or all below)

1) The co-payment amount for each session.
2) The balance remaining after receiving the explanation of benefits from my insurance company.
3) The no-show and late cancellation fee stated in my contract.
4) All of the above Card #

Expiration Date:

Type of Credit Card (Visa/Mastercard):

Zip Code of Credit Card Billing Address:

Signature Date

Name (Print as Seen on Credit Card) Date

*If you want to pay with checks or cash do not complete this form.

PERFORMANCE INSIGHT, LLC
CONSENT FOR TREATMENT

I, , voluntarily consent to psychological services
(name of client)
provided by Performance Insight. I have read the information contained in the Policies and Procedures document and the South Carolina Privacy Notice Form and agree to abide by its terms during our professional relationship. I understand that I am responsible for payment of any fees which insurance does not pay or cover.

I am aware that I may be asked to complete psychological questionnaires and/or tests as part of my evaluation and treatment. I understand that the results of these questionnaires may also be used in scientific research and/or to insure the quality of services offered through Performance Insight. However, when used in this manner, my confidentiality is assured by the data being combined with that of other Performance Insight clients and all identifying information will be removed. I understand that Dr. Scott A. Dreyer might consult with other psychologists/mental health professionals regarding my treatment. I am aware that any information discussed with a colleague of Dr. Scott A. Dreyer's will be kept confidential and my identity will be protected.

While receiving services, I have the right to ask for a referral and/or the right to terminate services at any point, if I choose to do so. I have the right to ask about alternative methods for addressing my concerns. I also recognize that my psychologist has the right to terminate services or refer me for assistance elsewhere, if he believes it would be in my best interest. I also understand that if I believe that my psychologist has engaged in illegal, unethical, or incompetent action, I may contact the South Carolina Board of Examiners in Psychology, P.O. Box 11329, Columbia, SC 29211-1329, (803) 896-4664, to make a written or verbal complaint.

Client/Guardian Signature Date

Witness Signature Date

INSURANCE/3rd PARTY AUTHORIZATION

I authorize the release of any medical or other information necessary to process insurance claims or 3rd party payment for services rendered. I also request payment of medical benefits to the undersigned psychologist or party who accepts assignment.

Client/Guardian Signature Date

Witness Signature Date

INTAKE FORM

Date Client Name_ SS#

o Home Phone_

Spouse/Parent/Guardian Name_ Work Phone_

Address_ o Cell Phone_

o

City_ State Zip *Please check box if OK to leave message
Occupation:_ Employer:_

Date of Birth: Age: Sex: Male o Female o

Race: Marital
Status:

Education Completed:_

Single o Emergency Contact:_
Married o
Separated o Emergency Contact Phone #:
Divorced o
Widowed o Religious Affiliation_

Briefly State the Nature of Your Current Concern or Problem (What brings you to Performance Insight at this time?):

Insurance Coverage: Yes o No o Name of Company:_
Name of Insured_ ID#
Name of Insured's Employer Insured's SSN#_

Insured’s Date of Birth:

Please furnish your insurance card for photocopy

Referred by (**use code below**)_ Name_

Referral Codes:

1. Friend/relative of client	5. Publicity (Yellow Pages, Internet)	8. Insurance
2. Former Client	6. Seminar/Workshop	9. Other Professionals
3. Clergy or MAP	7. Self-referral	10. Other Agency
4. EAP Employee Assistance Program		

For each of the following items, please check the appropriate space/box or provide the information requested. Please check “none” when appropriate.

Current Spouse/Partner: Name: _ Age:_
Occupation:_ o Full-time o Part-time

Education(''' highest): o Elem o HighSchool o College o Graduate

Children: #:_ # Living with you currently:_

Boys: ages

Girls: ages_

Employment History (list full-time positions except summer jobs since leaving HS):

DESCRIPTION	DATE STARTED – DATE STOPPED	REASON FOR LEAVING

Medical History:

1. **List serious illnesses, accidents, operations, hospitalizations, handicaps, chronic medical problems (e.g., diabetes, heart disease, asthma, etc.)………………. o None**

DESCRIPTION	AGE OF ONSET	TREATMENT

2. **Please describe any current medical condition(s):……………………………o None**

DESCRIPTION	AGE OF ONSET	TREATMENT

3. **Please list current prescribed & over-the-counter meds and dosages…….o None**

MEDICATION	DOSAGE	SCHEDULE TAKEN

4. Please list current herbal or dietary supplements (e.g., St. John's Wort, Gingko Biloba, Melatonin, vitamins, etc.) and dosages……………………………o None

HERB/SUPPLEMENT DOSAGE SCHEDULE TAKEN

Family of Origin: Parents separated/divorced… …………………o No o Yes D year_

Parents deceased: Father………………………o No o Yes D year_

Mother………………………o No o Yes D year_

Father: Occupation:_

Education ("' highest): o Elem o High School o College o Graduate

Mother: Occupation:_

Education ("' highest): o Elem o High School o College o Graduate

Number of siblings: Female Male_ Your birth order_

Family Medical History (please specify if applicable to anyone in your family):

1. Medical Disease (e.g., diabetes, thyroid, heart disease, etc.)…………………o None

Relationship to you	Specific Problem/Disorder
Relationship to you	Specific Problem/Disorder

2. Mental Health Problem (e.g., anxiety, depression, mania, psychosis etc.)...o None

Relationship to you	Specific Problem/Disorder
Relationship to you	Specific Problem/Disorder

3. Learning/Attentional Problems (e.g., dyslexia, ADHD, reading problems)...o None

Relationship to you	Specific Problem/Disorder
Relationship to you	Specific Problem/Disorder

4. Excessive Use of Alcohol or Drugs:…………………………………………………o None

Relationship to you

Relationship to you

Prior Mental Health Services (e.g., counseling, drug abuse treatment, hospitalizations):

Check All That Apply	Mo/Yr Started	Name of Counselor/Clinic	For How Long
o Counselor/Therapist	_ /_ _		

Issue/problem sought treatment for: _

- Counselor/Therapist _ /_ _

Issue/problem sought treatment for: _

- Hospitalization _ /_ _

Issue/problem sought treatment for:_

- o Coaching _ /_ _

Issue/problem sought treatment for:_

Prior Use of Psychotropic Medications (e.g., Adderall, Paxil, Lithium, etc.) ……….o Never

MEDICATION	DOSAGE	NUMBER OF MONTHS TAKEN

SCREEENING MEASURES

INSTRUCTIONS: Please answer the questions on the following pages about your alcohol and drug use, experience with traumatic events and weight and eating concerns

1. What is your current height (feet and inches) _ and weight (lbs) ?

2. Do you ever feel guilty about eating? For example, if you eat "wrong" foods (circle response below).

\- **0** **2** - **3**-

No Yes, sometimes Yes, often

3. How often do you eat less in front of other people and make up for it when alone?

- **0**- Never - **1**- Rarely - **2**- Often - **3**- Always

4. How often do you give too much time and thought to food?

- _**0**__ Never - **1**- Rarely - _**2**__ Often - **3**- Always

5. How conscious are you of what you are eating?

- **0**- Not at All - **1**- Slightly - **2**- Moderately - **3**- Extremely

6. Have you been on a diet to lose weight in the past two months?

- **0**- - **2** - _**3**__

No Yes, but not dieting now Yes, and am still dieting

7. Would a weight gain of 5lbs. affect the way you live your life?

0	1	2	3
Not at all	Slightly	Moderately	Very Much

8a. Please indicate which of the following tobacco products you have used in the past 30 days

o Cigarettes o Cigaro Smokeless tobacco o Pipe

8b. How many times a day do you use tobacco on average?_

9a. Please indicate which of the following caffeinated beverages you have used in the past 30 days.

o Coffee o Diet Soda o Regular Soda o Tea o Other

9b. How many 8oz. drinks per day on average do you drink?_

The following three questions are about alcoholic beverages. For these questions a drink means any of the following:

12-oz can/bottle of beer	12 ounce bottle of wine cooler/malt beverage
4-oz glass of wine	Mixed drink or shot glass containing 1-oz of liquor

10a. In the past 30 days, on how many occasions do you drink alcohol (check box)?
o 0 o 1-2 o 2-3 o 3-5 o 6-9 o 10-19 o 20-30

10b. On those occasions, when you drink alcohol, how many drinks do you have ?

11. In the past 30 days, how many times did you have 5 or more drinks in a row?
o 0 o 1 o 2 o 3-4 o 5-6 o 7-9 o 10+

12. Please answer the following questions about other drugs that you may have used (circle response):

	Lifetime (Number of occasions)	Past 30 days _(Number of occasions)

A. Amphetamines	0	1-2	3-5	6-9	10-19	20-39	40+	0	1-2	3-5	6-9	10-19	20-39	40+
B. Cocaine	0	1-2	3-5	6-9	10-19	20-39	40+	0	1-2	3-5	6-9	10-19	20-39	40+
C. Hallucinogens	0	1-2	3-5	6-9	10-19	20-39	40+	0	1-2	3-5	6-9	10-19	20-39	40+
D. Marijuana	0	1-2	3-5	6-9	10-19	20-39	40+	0	1-2	3-5	6-9	10-19	20-39	40+
E. Other drugs (list)														
_	0	1-2	3-5	6-9	10-19	20-39	40+	0	1-2	3-5	6-9	10-19	20-39	40+

	Yes	No
13. Do you feel you are a normal drinker?	1	0
14. Do friends or relatives think you are a normal drinker?	1	0
15. Have you attended a meeting of Alcoholics Anonymous (AA?)	1	0
16. Have you ever lost friends or a relationship because of drinking?	1	0
17. Have you ever gotten into trouble at work (school) because of drinking	1	0
18. Have you ever neglected your obligations, your family, or your work for two or more days in a row because of your drinking?	1	0
19. Have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that weren't there after heavy drinking?	1	0
20. Have you ever felt guilty or thought you should cut back your drinking?	1	0
21. Have you ever been in a hospital for drinking?	1	0
22. Have you ever been arrested for drunk driving or driving after drinking?	1	0
23. Have you ever experienced any significant interpersonal, occupational, academic or legal consequences from you use of alcohol/drugs?	1	0

INSTRUCTIONS: This next set of questions asks about stressful life events that you may have experienced either as a child or adult. For each event, please circle "yes" or "no".

If you experienced the event, it is helpful to know: A) your age when it first happened and last happened; B) whether you experienced intense fear, helplessness, or horror during the event (Yes/No); and C) whether you feared or experienced serious injury during the event. (Note: please report incidents that occurred whether or not they were reported to the police, family or friends – remember your file is confidentially protected).

Event	Happened	A AGE	B FEAR	C INJURY
1. Have you ever been in a serious accident (e.g., car accident, accident at work?)	NO	1st-	NO	NO

Describe_	YES	Last_	YES	YES

2. Have you ever been attacked without a weapon by anyone (e.g., stranger, spouse/partner, friend) who intended to kill or seriously injure you? Describe:_	NO YES	1st_ Last_	NO YES	NO YES

3. Have you ever been attacked with a weapon by anyone (e.g., stranger, spouse/partner, friend) who intended to kill or seriously injure you? Describe:_	NO YES	1st_ Last_	NO YES	NO YES

4. Has a romantic partner ever physically attacked you so that you suffered some degree of injuring including bruises, cuts, or other marks? Describe:_	NO YES	1st_ Last_	NO YES	NO YES

5. Did a parent or other guardian (e.g., babysitter grandparent) ever use physical punishment on you that resulted in some type of injury? (e.g., bruises) Describe:_	NO YES	1st_ Last_	NO YES	NO YES

6. Have you ever been in a situation where someone used/threatened physical force or any other type of pressure or coercion to try to make you have some type of unwanted sexual contact (e.g., contact with their sexual organs or them contacting your parts) Describe:_	NO YES	1st_ Last_	NO YES	NO YES

Event	Happened	A	B	C
		Age	Fear	Injury
7. Did this incident or any of these incidents include forced unwanted vaginal, oral, or anal penetration either by an assailant's penis or the use of fingers tongue, or some other object? Describe:_	NO YES	1st_ Last_	NO YES	NO YES

8. Before you turned age 16, did you ever have any type of sexual contact with another person who was five years older than yourself? Describe:_	NO YES	1st_ Last_	NO YES	NO YES

9. Did you experience any other traumatic events as a child or adult?	NO	1st-	NO	NO

Describe:_ YES Last_ YES YES

READ EACH OF THE FOLLOWING QUESTIONS/STATEMENTS AND CIRCLE or CHECK THE BOX THAT BEST APPLIES TO YOU.

1) Have you EVER experienced the following problems nearly every day for a two-week period?

Depressed mood for most the day?	YES	NO
Diminished interest or pleasure in most activities?		
Significant weight loss or weight gain which was not intentional?		
Trouble falling asleep, trouble staying asleep, or sleeping too much		
Fatigue or loss of energy		
Feelings of worthlessness or excessive guilt		
Indecisiveness or decreased concentration		
Recurrent thoughts o death or suicidal ideas		
Have you ever has a suicide attempt?		

Are you experiencing these symptoms now? If not when?_

2) Please answer the following questions:

Are you preoccupied with food and eating?	YES	NO
Do you ever vomit after eating?		
Have you gone on an eating binge during which you ate larger amounts of food than most people would eat?		
Do you at times feel as though you do not have any control over your eating?		
Have you ever used laxatives or diuretics in an attempt to control your weight?		
Do you avoid eating certain foods, such as sweets or fried foods?		

3) Please answer the following questions

Have you EVER experienced an episode or spell during which you suddenly felt very afraid or very anxious for no apparent reason (If "NO" skip to question 4)?	YES	NO
Did the fear you experienced during the episode reach a peak within 10-60 min?		
During the episode, did you experience your heart pounding?		
During the episode, did you experience sweating?		
During the episode, did you experience trembling or shaking?		
During the episode, did you experience shortness of breath?		
During the episode, did you experience chest pain?		
During the episode, did you experience nausea, GI problems or vomiting?		
During the episode, did you experience dizziness or light-headedness?		
During the episode, did you experience numbness or tingling in your hands and/or face?		

Have you been experiencing these symptoms recently? If not when_

4) Please answer the following questions:

Have you ever experienced an intense and persistent fear of a social situation that required you to perform in front of others?	YES	NO
Have you ever experienced an intense or persistent fear of a situation in which you thought others might be judging or evaluating you?		
Do you avoid feared social or performance situations or endure them with intense anxiety?		
Do you believe that your fear of social situations is excessive or unreasonable?		
If you are placed in a feared social situation do you experience intense anxiety?		
Do you fear in social situations that you will be humiliated or embarrassed by your actions?		

5) Please answer the following questions:

Have you ever been bothered by unwanted, persistent thoughts, images or impulses that seemed silly or horrible?	YES	NO
Have you ever been bothered by a persistent thought, impulse or image that seemed unreasonable or excessive?		
Have you ever been bothered by thoughts, images or impulses that you couldn't get out of your mind that caused you to experience intense anxiety?		
Have you ever felt compelled to repeat certain behaviors (e.g. hand washing) or thoughts (e.g. counting or repeating words)?		
Do you wash yourself or other things excessively?		
Do you worry excessively about germs or dirt?		
Do you keep useless things, not because you need them but because you cannot throw them away?		
Do you have to check things again and again to be sure that they were done correctly?		

6) Please answer the following questions:

Are you preoccupied with a desire to be thinner?	YES	NO
Do people think you are too thin?		
Do others frequently urge you to eat more?		
Do you avoid eating when you are hungry?		
Are you afraid of being overweight?		
Do you weigh yourself frequently?		
Do you think you are overweight, although others tell you that you appear thin?		
Do you try on key items of clothing to make sure you have not gained weight?		

7) Please answer the following questions:

Have you experienced excessive anxiety or worry (please circle), occurring more days than not for at least 6 months?	YES	NO
Do you find it difficult to control the worrying?		
Do you worry unreasonably or excessively about many different things (e.g. work school, or family members)		
Does anxiety interfere with your ability to perform your daily activities?		
When you are worrying or feel anxious do you experience any of the following?		
Restlessness or feeling on edge?		
Being easily fatigued?		
Difficulty concentrating?		
Irritability?		
Muscle tension?		
Difficulty falling or staying asleep?		

8) Please answer the following questions:

Have you ever experienced or witnessed an event that involved actual or threatened death or serious injury to yourself or others that caused intense fear or horror (e.g. a severe car accident, childhood physical or sexual abuse, assault, rape etc.)	YES	NO
Do you re-experience the event in any of the following ways:		
Repeated distressing memories or dreams?		
Acting or feeling as if the traumatic event were recurring (e.g. flashbacks/reliving it)?		
Intense psychological distress or physiological arousal when exposed to things that remind you of the traumatic event?		
Do you avoid things that remind you of the traumatic event (e.g. activities, places, or people)?		
Are you unable to recall an important aspect of the traumatic event?		
Since the traumatic event have you experienced diminished interest or participation in activities you previously enjoyed?		
Since the traumatic event have you experienced a sense of detachment or estrangement from others?		
Since the traumatic event have you experienced persistent symptoms of increased physiological arousal as indicated by any of the following?		
Difficulty sleeping?		
Irritability or outbursts of anger?		
Decreased concentration?		

9) Please answer the following questions:

Have you ever been hospitalized for a psychiatric disorder?	YES	NO
Have you ever experienced a period of time during which you were paranoid, thinking that other people were talking about you or were out to get you?		
Have you ever experienced a period of time during which you felt as though your thoughts, feelings or actions were being controlled by some outside force?		
Have you ever experienced a period of time during which you heard voices when no one was present?		
Have you ever experienced a period of time during which you saw a vision or something else that others were unable to see?		
Have you had an experience during which you felt that people on the radio or TV were talking to you or about you?		
Have you ever had an experience during which you thought that others could read your mind?		

10) Please answer the following questions:

Have you ever had a period of one week or more during which you experienced an abnormally happy or irritable mood?	YES	NO
Have you ever had a period of one week during which you persistently experienced and inflated sense of self-esteem or thought you had special powers?		
Have you ever had a period of one week during which you needed much less sleep that is usual for you and did not feel sleepy?		
Have you ever experienced a period of one week during which you felt as thought your thoughts were racing or you were unusually talkative?		
Have you ever experienced a period of one week during which you were "hyper", agitated, or started too many projects at once?		
Have you experienced a one-week period of time during which you were very impulsive or became involved in activities that caused your family or friends to be worried about you?		

11) Please answer the following questions:

Do you get distracted easily (e.g. by your thoughts or by external distractions)?	Yes (as a child)	Yes (now)	No (Never)
Are you prone to making careless mistakes and not paying attention to details?			
Do you have difficulty sustaining your concentration on tasks that require a good deal of your attention?			
Do you have difficulty listening to others when you are spoken to?			
Do you have problems following instructions or following-through with directions?			
Do you lose things regularly and spend a good deal of time looking for these objects?			
Are you frequently forgetful?			
Do you have difficulty waiting your turn?			
Do you interrupt others?			
Do you feel as though your thoughts and/or body are driven like a motor?			
Are you frequently restless and find yourself fidgeting?			
Would you characterize yourself as an impulsive person?			

10/01/2014

SOUTH CAROLINA PRIVACY NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.

- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to

obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** When in my professional capacity, I have received information which gives me reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, I must report such to the county Department of Social Services, or to a law enforcement agency in the county where the child resides or is found. If I have received information in my professional capacity which gives me reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by acts or omissions that would be child abuse or neglect if committed by a parent, guardian, or other person responsible for the child's welfare, but I believe that the act or omission was committed by a person other than the parent, guardian, or other person responsible for the child's welfare, I must make a report to the appropriate law enforcement agency.

- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited, I must report the incident within 24 hours or the next business day to the Adult Protective Services Program. I may also report directly to law enforcement personnel.

- **Health Oversight:** The South Carolina Board of Examiners in Psychology has the power, if necessary, to subpoena my records. I am then required to submit to them those records relevant to their inquiry.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me the intention to commit a crime or harm yourself, I may disclose confidential information when I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. In this situation, I must limit disclosure of the

otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.

- **Workers' Compensation:** If you file a workers' compensation claim, I am required by law to provide all existing information compiled by me pertaining to the claim to your employer, the insurance carrier, their attorneys, the South Carolina Worker's Compensation Commission, or you.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will . . .[*Notice must also describe how the psychologist will provide individuals with a revised notice, e.g., by mail*.]

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact [*add name, or title,*

and telephone number of a person or office to contact for further information.]

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on _ [*add date, which may not be earlier than the*

date on which the notice is printed or otherwise published.]

[If you (the psychologist) elect to limit the uses or disclosures that you are permitted to make under this subpart, add the following:]

I will limit the uses or disclosures that I will make as follows:

[Note – You (the psychologist) may include in your notice a limitation (a restriction) affecting your right to make a use or disclosure. This restriction, however, may not include a limitation affecting the psychologist's right to make a use or disclosure that is required by law or, when in good faith, to use or disclose to avert a serious threat to health or safety of a person or the public and such use or disclosure is made to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat)].

[*If you (the psychologist) want to apply a change in your more limited uses and disclosures to PHI created or received prior to issuing a revised notice, the revised notice must include a statement that you reserve the right to change the terms of the notice and to make the new notice provisions effective for all protected health information that you maintain. The statement must also describe how you will provide individuals with a revised notice. (See example below.)]*

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by [*Describe how you will provide individuals with a revised notice.]*

PATIENT'S INSURANCE WORKSHEET

You should be informed as to your coverage, since you're responsible for any part of your bill not covered by insurance. Even though we deal with the major insurers frequently, even the same insurer has different plans for different employers. It's always better to find out the plan specifically related to you. Insurance companies always say the information given over the phone is not binding. READ YOUR POLICY! Bring it in to go over with Dr. Dreyer/Dr. Bradham or Melinda (Office Manager) if you have trouble understanding it. Call the number listed on your card for MENTAL or BEHAVIORAL HEALTH BENEFITS.

Date and time of call to insurance company	
"What is your name?" (Get the name of EVERY person you talk to).	
Verify that this number is the one to call regarding MENTAL HEALTH benefits.	
Do I need a referral from a physician?	
"Does Dr. Dreyer/Dr. Bradham need to precertify coverage?" (If so, call us immediately & let us know!)	
"Will Dr. Dreyer/Dr. Bradham need to recertify coverage at some point? If so, when and how?	
Performance Insight's initial charge for an evaluation and brief testing is $175 per hour, and it usually takes 1- 1 1/2 hours. Will this be covered, and at what rate? (Billing code 90801)	
"Dr. Dreyer/Dr. Bradham charges $125/hour for psychotherapy (billing code 90806). Will you pay a certain % of $125, or is there a lower MAXIMUM ALLOWABLE CHARGE?"	
Ask if you have a NETWORK and if Dr. Dreyer/Dr. Bradham is in the network.	
What is the maximum number of sessions per year?	
What is the maximum dollar amount covered per year for outpatient MENTAL HEALTH?	
What is my deductible dollar amount?	$
How much of the deductible have I met?	$
When does my deductible year start?	
"Do I have a specific dollar amount co-payment?" If yes, "how much is it?	$
Verify the ADDRESS for sending Mental Health claims:	

Notes:

PERFORMANCE INSIGHT, LLC
Mobile: (843) 367-1014
Email:drdreyer@performanceinsight.com

AUTHORIZATION FOR EXCHANGE OR RELEASE OF INFORMATION

I, , , _

(Name of Client) (Date of Birth) (SS#)

give my permission to: , _

(Therapist/Practice Name) (Phone Number)

to exchange information with: , _

(Name) (Phone Number)

(Address)

Information to be exchanged includes: _

I understand the content to be released/obtained, the need for the information and that there are statutes and regulations protecting confidentiality of authorized information. I understand that this consent is truly voluntary and is valid until (date not to exceed one year). I also understand that I may withdraw this consent at any time except to the extent that information has already been exchanged.

Client or Parent, Guardian, or Legally Appointed Representative Date

Therapist/Witness Date

Release Revoked: _

Client or Parent, Guardian, or Legally Appointed Representative Date