Dialectical Behavior Therapy Center

1348 Heights Blvd
Houston TX 77008-4209
713-973-2800

INFORMED CONSENT

Thank you for choosing the Dialectical Behavior Therapies Center to address your goals in creating the life that you want to live and share. We are honored to help you.

To facilitate understanding and clear communication, this document contains important information about professional services and business policies. Please read it carefully and discuss any questions that you might have with your therapist. When you sign this document, it will represent an agreement between you and the DBT Center.

PSYCHOTHERAPY SERVICES

At the DBT Center, we offer various types of therapy, coaching and counseling. We offer both telehealth sessions and in person sessions. You and your therapist will discuss the particular plan that best fits you and your goals.

Telehealth services could include video sessions or phone sessions and could be individual, family, or group sessions. You can request to be seen in person rather than in Telehealth sessions.

When group sessions are conducted via Telehealth, it is possible that your confidentiality could be breached if others in the group are not in a confidential setting or if you are not in a confidential setting. In order to reduce risks to confidentiality, we suggest that all video or telephone sessions occur in a private room with no one else present and that you wear headphones to limit the possibility of other people overhearing confidential information.

There are potential risks associated with telehealth, such as failure of security protocols that may cause a breach of privacy of personal and/or medical information. If you have any concerns about Telehealth services, please discuss these concerns with your therapist.

All therapy can have risks. It can be unpleasant to discuss feelings like sadness, guilt, anger, and loneliness. On the other hand therapy has also been shown to have benefits such as improved relationships, improved skills in managing emotions, and significant reductions in feelings of distress. It can help you find what is blocking your happiness in life. But there are no guarantees of what you will experience.

ELECTRONIC MEDICAL RECORD

Your file is kept online with a company that specializes in electronic records. We do not keep paper files. We require written authorization to release your records as these records contain confidential information about you. Copies of your records can be provided for $25.00 for the first 20 pages and

$.50 a page after that, plus any mailing costs.
Records will be released after we have authorization and payment for the copies.

EMAIL AND TEXTS

It's not possible to guarantee the confidentiality of email or texts. If you have concerns, we encourage you to call instead of emailing or texting, even though we use encrypted email and texts. Please use email and texts only for coaching or scheduling or communicating brief information.If you are sharing clinical information, please call or email. Please be aware that texts and emails may be a part of your clinical record.

CANCELLATIONS

Keeping appointments is important to your success. If you have to miss an appointment, we ask that you give 24 hours notice. For appointments cancelled less than 24 hours, you will be charged for the appointment. Keep in mind that insurance does not pay for missed appointments, thus you would be responsible for the full charge for the session, not just the co-pay.

EMERGENCIES

Therapists are often not immediately available by telephone and rarely take calls when in sessions with clients. Therapists usually return calls the same day they receive them with the exceptions of weekends, holidays and vacations. Please discuss emergency call and coaching call arrangements with your therapist. If you are unable to reach your therapist, contact your psychiatrist, family physician, call 911, or go to the nearest emergency room.
When your therapist is unavailable for a length of time, you will be given the name of a colleague who will be on call.

PROFESSIONAL FEES AND PAYMENT

If you have insurance coverage through a managed care company and we are contracted with the managed care company, payment will be according to the agreement made with your managed care company.

All therapists have different hourly rates which will be discussed with you prior to the appointment. The hourly rate for your therapist will be charged for time involved for other services you may need. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries and the time spent performing any other service you may request.

Our adult and our teen IOP is not covered by any insurance company.The charge for the adult intensive outpatient program (9 hours per week) is $1080 per week. The charge for the teen IOP is $780 per week.

Payment is due at the time of the session unless agreed otherwise. While we hope it never happens, if your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon we have the option of using a collection agency to collect the unpaid bill and to give the agency whatever information is needed to collect.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Authorization may be required before the insurance company will provide reimbursement. At times the insurance plan limits the number of sessions for which they will pay.

Most insurance companies require us to provide them with a clinical diagnosis and specific information about your symptoms and goals. We often may have to provide additional clinical information such as treatment plans or summaries or information about your progress. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies have policies to keep such information confidential, we have no control over the information that is given to them. In some cases the information may be shared with a national medical information databank. If you are not comfortable with this situation, it is important to remember that you always have the right to not use your insurance benefits.

LEGAL ISSUES/COURT EVALUATIONS

DBT Center therapists are not trained as forensic specialists and do not complete evaluations for legal purposes. Forensic psychology and custody evaluations are specialized fields and we do not give reports or recommendations in these areas as we are not trained evaluators in these areas. Should you become involved in other legal proceedings and your therapist is required to participate, you will be responsible for the professional time even your therapist Is called to testify by another party. Because of the difficulty and time demands of legal involvement, the charge is $380 per hour for all therapists for preparation, travel and attendance.

CONFIDENTIALITY

In general the privacy of all communications between a patient and a therapist is protected by law and your therapist can only release information about your work to others with your written permission, but there are a few exceptions.

There are some legal proceedings, such as those involving child custody, when a judge may order testimony and/or release of records. In these cases our records would reflect treatment goals and your progress, but not an evaluation for custody or other such issues.

If your therapist believes that a child, elderly person, or disabled person is being abused; your therapist must file a report with the appropriate state agency. If your therapist believes that a client is threatening serious bodily harm to another, protective actions may be required, such as contacting the police or family members. If a client threatens to harm himself/herself the therapist will contact family members or others. If your therapist learns of sexual exploitation by a mental health provider, they are required to report. If a client is a minor, then legal guardians/parents have the right to see the clients' record. As confidentiality is critical for success of therapy, we ask that parent not access the record. The therapist will inform parents if there is reason to believe that the minor is involved in dangerous activities or is a danger to themselves or others.

These situations have rarely occurred here, but if such a situation occurs, your therapist will make every effort to discuss it fully with you before taking action.

DBT and RO DBT therapists participate in Team Consultation. As a team, we will at times discuss the progress of your therapy. Sometimes we find it helpful to consult other professionals, making every effort to avoid revealing the client's identity. The consultant is legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless your therapist feels that it is important for your work together.

Please know that at the front and back entrances to the DBT House, we have video doorbells. The video from these doorbells is not kept and is viewed only by DBT Center staff as a security measure.

PARENTS OF MINORS

While privacy in therapy is crucial for successful progress, parental involvement is also essential. Therapists will share with parents the treatment plan, goals, and progress toward goals. Therapists will share any disclosure of abuse or any plan to harm themselves or others, or any risky behavior that could result in immediate and server harm.

If you are a parent or guardian who is consenting to treatment for a minor, by signing this agreement you affirm that you are the parent or legal guardian and that you have the legal right to consent to treatment, and that there has not been a divorce decree or court order that limits your ability to consent to the minor's treatment.

IF YOU ARE THE PARENT OF A MINOR AND SEEKING TREATMENT FOR THE MINOR, AND YOU ARE DIVORCED, WE REQUIRE A COPY OF THE DIVORCE DECREE. Please submit a copy of the decree with your intake forms.

THERAPISTS

Our therapists have different degrees and training. All our therapists are licensed. If you see an LMSW or an LPC- A, those therapists are working under supervision of another therapist. In this case, your therapist will give you the name of their supervising therapist. Currently Beth Reese, E-RYT, LPC-A is under the supervision of KimberlyHarrington-Delgado, LPC-S, RPT-S, EMDR Approved Consultant. Frances Fisher, LMSW, CTRS, RYT-200 is under the supervision of Jennifer Edwards, LCSW, as is Jessica Brady, LMSW

At times we have student therapists who participate in our groups with a licensed therapist and who offer sessions at a discounted rate. You will be informed of any services that are being offered by a student under supervision. Your treatment will not be affected in any way if you choose to not to allow a student to be part of your sessions.

Complaints

Should you have any complaints about your treatment, please discuss these complaints with your therapist or with the clinical director of the practice, Kelly Guynes, LCSW. If we are unable to resolve the complaint you may choose to report the therapist to their licensing board. Therapists with different licenses also have different licensing boards. You may complain about any HIPAA Privacy violations to the US Department of Health and Human Services at OCRMail@hhs.gov.

PROFESSIONAL RELATIONSHIP

In order for your professional relationship with the therapist to be helpful and supportive, it must be free of any complications that might influence objectivity or lead to a conflict of interest or taking unfair advantage of either party. For those reasons, business, personal, or other outside relationships between therapist and client are not permitted. This policy is in accordance with the ethics codes for licensed therapists.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. At any time that you have any question about the information given here or about your treatment, please let your therapist know.

First and Last Name:

Date:

ABOUT YOU

Please answer the following questions to help us best use your appointment time.

Family Relationships

Who does the client live with?

Are you in a committed relationship? Please describe.:

Are you a parent of a minor who is divorced and seeking treatment for the minor? (If so, please attach a copy of the divorce decree.):

Do you have a religious preference? Please describe any religious beliefs and values that we need to be aware of.:

Reason for Appointment: What Are Your Concerns?

What is your major goal you want to accomplish in therapy?

Have you been in therapy previously?

If Yes, enter the names and phone numbers of previous therapist(s) seen and briefly describe treatment:

Was therapy helpful?:

Please list the names of any hospitals and dates of hospitalizations if any.:

Do you have concerns with any of the following?

(check all that apply)

___Addictions (Gambling, Drugs, Alcohol, other)

___Anxiety

___ Anger Issues

___Anorexia

___Bulimia

___Binge Eating

___Unspecified eating or feeding disorder

___ Body Image Issues

___Depression

___Suicidal thoughts

Have you ever made a suicide attempt? Please give dates

___Not achieving what you'd like to achieve in

your life

___Impulsive behaviors __ Difficulty concentrating

___Grief

___Mood Swings

__Panic Attacks

___Trauma

___Substance abuse (Please describe):

___Inability to have fun

___History of abuse

___Work or career difficulties (please

describe):

Please give us any information about your symptoms and reasons for seeking therapy that you think would be helpful:

Medical History and any Current Medical Conditions Write "NA" if it does not apply

Name of your Psychiatrist, Pediatrician and/or Family Doctor:

What medications are you currently taking?:

What medications do you have that you aren't currently taking?:

Please let us know of any physical disorders that you have.:

Family History

___Family history of eating disorders

___Family history of anxiety

___Family history of autism
___Family history of depression
___Other

REFERRAL INFORMATION

How did you hear about the DBT Center?:

Please provide the information of the name, phone number and email of the person who referred you. If it was an online search please write "N/A"

NAME

PHONE NUMBER:

ADDRESS:

EMAIL ADDRESS:

EMERGENCY CONTACT FORM

Your safety is a primary concern. Should you need medical attention for any reason, have a health concern, or your therapist is concerned about your safety, we need to know who to contact.

CLIENTS INFORMATION

Client Name: Date of Birth: Home phone: Cell phone:

Address:

City: State: Zipcode:

MAKE, MODEL AND COLOR OF CAR:

LICENSE PLATE NUMBER:

ANY PHYSICAL ILLNESSES:

LIST ALL MEDICATONS WITH DOSAGES:

EMERGENCY CONTACT

Name Relationship:

ER Contact's Cell Phone: Work phone:

Name of Second Emergency Contact:

Relationship of Second Emergency Contact:

Phone:

.

ELECTRONIC RECORDS AND COMMUNICATION

CLIENT NAME:

CLIENT DATE OF BIRTH:

CLIENT EMAIL ADDRESS:

CLIENT CELL PHONE:

We typically use encrypted email and encrypted texting to communicate with you concerning appointment times, billing information, and in answering questions that you might have. However we cannot assure the confidentiality of email or texts that we send to you or that you might send to us.

This form when completed and signed by you authorizes the DBT Center to communicate with you electronically for the following (please choose

☐ Appointment

Reminders ☐ Payment

receipts

☐ Billing Statements

☐ DBT Newsletter

You have the right to revoke this authorization, in writing, at any time by sending written notification to the DBT Center's office address. By typing or writing your First and Last Name below, you are agreeing that you will receive electronic communications from the DBT Center.

Name:

Date:

Blueprint Automated Notetaker Informed Consent

Your clinician has opted to use Blueprint's note-taking system as part of their effort to provide excellent care to clients and provide a concise and complete clinical record.

Blueprint's note-taker temporarily records sessions and uses this recording to automatically generate a progress note (a required form of clinical documentation) after a progress note is generated, the recording is automatically deleted from Blueprint's servers and database.

Use of this technology allows your therapist to be fully present during your sessions without having to slow down to take notes or try to remember important information during the session. This allows them to focus all of their attention on your care.

Blueprint's software is HIPAA compliant and SOC 2 Type 2 certified, which means an external third-party auditor reviews Blueprint's systems, policies and processes on an ongoing annual basis to ensure Blueprint meets certain data privacy and security standards.

By signing this consent form, you are agreeing to allow your clinician to record your sessions and utilize software to assist them in generating progress notes to document your treatment.

Client Full Name: _____

Parent/guardian for minors:_____

Date:_____

FINANCIAL POLICY

In an effort to make sure that there is no undue stress in regards to the billing of your account, please review our financial polices.

1. Notify us immediately of any changes in your insurance, as changes in your insurance plan could also mean changes in your coverage for our program. The insurance company does not notify us. Our office will need at least 72 hours to verify coverage and benefits. The client will be Self pay until coverage is verified.

2. Please know that verification of benefits is not guarantee of payment. You are responsible for payment should insurance not cover the charges. Payments are charged to your card as soon as we are informed.

3. All charges regarding your account are ultimately your responsibility. If you would like a statement of your account, please ask the administrative staff.

4. Copays are due in full on the date of service. Paying the copay is required for continued care.

5. If payment for fees is not received at the time of the visit, your credit card on file will be charged.

6. All sessions, including IOP sessions, not cancelled 24 hours in advance will result in a charge at the same rate as a session or the rate set by your insurance company. The charge is the full session rate, not the copay.

7. There is a $35.00 fee for each returned check and a $25.00 fee for declined credit or debit cards. If your card is declined or your check is returned twice, we will require cash payments for future services.

10. A credit/debit card must be on file. This card will be charged for any payments for sessions, missed sessions, book purchases and late cancellation fees. If you wish to change the card on file, notify the admin staff prior to your appointment.

If you are paying for services for a client and want to check for any no-show or late cancellation charges, please call the billing department at 346-231-0328 or email at stephanie@dbtcenterhouston.com. You will not be automatically notified of missed session charges.

By typing or writing your first and last name below, you are agreeing that you have read and understand this form:

Name _____(Responsible party)

Date: _____

COORDINATION OF BENEFITS

Client Name:

Client's Date of Birth:

Please check indicating you have one of the following insurance benefits

programs ☐ Aetna Behavioral Health

☐ Blue Cross Blue Shield (PPO

Only) ☐ Cigna Behavioral Health

We do not accept Third Party Plans with Cigna. (Alligiance is a Third-Party Plan. Please check mark box below " I am aware that the DBT Center is not a covered provider"

OR Initial indicating you understand the following

☐ I am aware that the DBT Center is not a covered provider for any other insurance company other than those companies listed above. If I have any other insurance plan (including Medicare), I am aware that I will be considered a cash pay patient, and I will be responsible for filing for reimbursement from my insurance company. I understand that the DBT Center is not responsible for insuring or helping to get reimbursement from my insurance carrier.

Insurance Policy Information

Name of Policy Holder:

Date of Birth:

Relationship to Client:

Member ID:

Group ID:

Social Security Number:

Employer:

Name of Insurance Company:

Social Security Number of Dependent:

Benefits phone Number

I certify that all insurance information is true and accurate. I will notify you of any change in my insurance coverage.

By typing or writing your first and last name below, you are agreeing that you have read and understand this form.:

Name: _____

CREDIT CARD AUTHORIZATION

The Dialectical Behavior Therapies Center is hereby authorized to maintain credit card payment information in their secure and confidential files. This form is being provided for you to supply the DBT Center with this information for an automatic payment option. Your signature authorizes us to review this information and deduct our fees for professional services rendered from the credit card(s) listed below. A card must be placed on file prior to attending any sessions at the DBT Center. If you wish to change the payment method please email Stephanie@dbtcenterhouston.com. If a card is not filled in below the appointment may have to rescheduled. Please note we must have the credit card holders name and signature on file.

Name: Address:

City/State/Zip:

Phone: Email:

PRIMARY CREDIT CARD
Name on Card:

Credit Card Number: Expiration Date: CVC#:

choose one)

___Visa

___Master Card
____American Express
___ Discover

By signing this form, I give permission to the Dialectical Behavior Therapies Center to charge my above credit card(s) for fees related to their professional services. If I am using my company's credit card, I am signing as an authorized user. My signature below confirms my knowledge and acceptance of fees, terms, and policies of Dialectical Behavior Therapies. I understand and agree to accept responsibility for payment of any and all professional services rendered should my credit card(s) deny all or part of this charge as it will then become solely my responsibility. I also understand that this authorization will remain in effect unless I cancel this authorization in writing.

First and Last Name:
Date::

Your Rights and Protections Against Surprise Medical Bills

When you see an out-of-network provider, you are protected from surprise billing or balance billing. This means that if we are not on your insurance plan, we need to let you know what your expected payment for services will be and that those payments are likely more than the costs you would have if you see an in-network provider. Payments to an out of network therapist may not count toward meeting your deductible with your insurance company. While many excellent therapists are not on insurance plans, you can choose to only get care from therapists who are on your insurance plan.

At the DBT Center, different therapists have different rates. You will be told the cost of your intake session prior to the session, and when we know which therapist you may be working with, you will be given a statement of the charges you will be responsible for. We will also provide you with receipts to send to your insurance company, as some insurance companies will reimburse you some of the costs of out of network care.

If you believe you've been wrongly billed, you may contact: The federal phone number for information and complaints is: 1 -800-985-3059.
Visit https://www.cms.gov/nosurprises for more information about your rights under

federal law. By Signing you have agreed you have received

Client Full Name:

RELEASE OF INFORMATION

By signing this form, you are authorizing the DBT Center to communicate with the person or organization you designate below. Your protected, confidential information will be released by the Center, received by the Center or both released and received (exchanged) by the Center and the designee, depending on the box you check below.

I Authorize...

DBT Center of Houston

1348 Heights Blvd, Houston, TX 77008

Phone: 713-973-2800 Fax: 877-421-2524

(check one)

☐ To release and receive

information ☐ To release

information only

☐ To receive information only

To/From...

Name::

Address::

Phone::

Fax::

I am requesting the release of this information for the following

reasons: ☐ Coordination of Care

☐ Other:

If other, please explain::

Substance abuse treatment is included in this

release: ☐ Yes

☐ No

This release includes the release of any information about

HIV/AIDS: ☐ Yes
☐ No

This authorization shall remain in effect as long as you are a client at the DBt Center. You have the right to revoke this authorization, in writing, at any time by sending written notification to the DBT Center’s office address. However, your revocation will not be effective to the extent action has been taken in reliance on the authorization or if this authorization was obtained as a condition of insurance and the insurer has a legal right to contest a claim.

First and Last Name:

Date::

.:

NOTICE OF PRIVACY PRACTICES

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

We understand that health information about you and your health care is personal. We are committed to protecting your health information. We create a record of the care and services you receive and we need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.

• Give you this notice of my legal duties and privacy practices with respect to health information.

• Follow the terms of the notice that is currently in effect.

• We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request from our administrator.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what w emean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. Some of the therapists do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For their use in treating you.
b. For their use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For their use in defending themselves in legal proceedings i
d. For use by the Secretary of Health and Human Services to investigate compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. We will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. We will not sell your PHI in the regular course of my business.

VI. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain imitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although our preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions;rotecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

VII. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT
1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
VIII. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:
1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say “no” if we believe it would affect your health care.
2. Important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say “no” to your request, but we will tell you why in writing within 60 days of receiving your request.
3. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

First and Last Name:
Date:

DERS

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

1. I pay attention to how I feel:
2. I have no idea how I am feeling.:
3. I have difficulty making sense out of my feelings.
4. I am attentive to my feelings.:
5. I am confused about how I feel. :
6. When I'm upset, I acknowledge my emotions.:
7. When I'm upset, I become embarrassed for feeling that way.:
8. When I'm upset, I have difficulty getting work done. :
9. When I'm upset, I become out of control. :
10. When I'm upset, I believe that I will remain that way for a long time.:
11. When I'm upset, I believe that I will end up feeling very depressed.:
12. When I'm upset, I have difficulty focusing on other things.:
13. When I'm upset, I become ashamed with myself for feeling that way.:
14. When I'm upset, I feel guilty for feeling that way.:
15. When I'm upset, I have difficulty concentrating.
16. When I'm upset, I have difficulty controlling my behavior. \
17. When I'm upset, I believe that wallowing in it is all I can do.
18. When I'm upset, I lose control over my behaviors.

OC Trait Rating Scale

Instructions: Listed below are a number of statements. Please read them carefully and decide how much each statement applies to you according to your present and past experiences. In completing this questionnaire, it is important to understand that there are no "right" or "wrong" answers. We are interested in finding out how people think, feel or behave across different settings and circumstances.

Use the following 6-point scale to rate the extent you agree or disagree with each statement: 1= Disagree completely 2 = Disagree strongly 3 = Disagree somewhat 4 = Agree somewhat 5 = Agree strongly 6 = Agree completely

1. When challenged by someone I tend to immediately deny, dismiss, or dispute the feedback.

2. There is always a right and a wrong way to do things.

3. My mind often goes blank when I have to speak about my feelings.

4. Very few people really know the real me.

5. I always make time for enjoyment or fun.

6. On the surface I appear calm, but inwardly I am often fearful or irritable.

7. My dream life involves having a new experience every day.

8. Most of the time life seems easy.:

9. I often feel detached from others

10. If I'm invited to a party I usually attend out of obligation, not because I expect it to be fun.

11. Most people may not know that I will do almost anything to get ahead.

12. I often feel compelled to correct mistakes made by others.

13. I am sometimes so open to new ideas that people have described me as naive or gullible.

14. Having to be around others for long periods of time is exhausting.

15. In life, there is a set of rules and principles that one should always adhere to.

16. I am proud of my ability to tolerate pain or distress in order to achieve a goal.

17. Most things in life don't work out.

18. I often notice errors that other people miss.

19. Very few people know that I can have an explosive temper.

20. My anxiety often interferes with my ability to hear what another person is saying.

21. I dislike details.

22. I find something positive or amusing in almost every situation.:

23. I often mask or hide my inner feelings from others.:

24. I feel content with my life

0. DBT Newsletter Enrollment

I would like to receive the DBT Center Newsletter

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