ayama
PSYCHOTHERAPY

First Meeting Date:_____

_____ _____ _____
Last Name First Name Middle Initial

Nickname (if any)_____

Date of Birth _____/_____/_____
Month/ Date / Year

Name of responsible party (for any balance owed): _____

Address of responsible party:_____

Emergency Contact: _____ _____
Name Phone

Gender: _____ Sex (if different than gender):_____

Marital Status: ◉ Single ○ Married ○ Separated ○ Divorced ○ Widowed
○ Living w/long-term partner

Referred by: _____

Home Address: _____ _____ _____ _____
Street City State Zip

Phone: (_____) _____-_____

Employer:_____

Check box: ☐ Part-time ☐ Full-Time ☐ Unemployed ☐ Disability

Primary Insurance Company _____

Policy holder's name and date of birth:_____ _____

Secondary Insurance Company_____

Policy holder's name and date of birth:_____ _____

Please be aware: We are not covered under HMO's, Medical Assistance or any Medicare other than Highmark Senior and Medicare of PA. Your insurance will not cover our services and restrictions prohibit from collecting out of pocket pay from these organizations.

Appointment Reminders, Online Appointment Scheduling, and Emailing

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit www.schedule.care (or therapyappointment.com) to check or cancel appointments.

Your name: _____

Where would you like to receive appointment reminders? (CHECK **ONE**)

☐ Via a text message on my cell phone (normal text message rates will apply),

Cell # to be used (___) _____

OR: ☐ Via an email message to the address listed above,

Email to be used_____

OR: ☐ Via an automated telephone message to my home phone, OR

Home # to be used (_____) _____

OR: ☐ None of the above. I'll remember my appointments on my own. Missed appointment fees will still apply.

What would you like to do regarding email (CHECK ONE):

☐ Yes, I authorize you to use email to correspond with me. I understand that the communication is not considered a secure form of communication and I accept this risk. Please use this email:_____

☐ No, please do not use email to correspond with me unless I initiate an email first. By initiating an email to my therapist, I understand that the communication is not secure and I accept this risk.

Appointment information and emailing of information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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Signature Date

Ayama Psychotherapy LLC
720 Pike Street, P.O. Box 1122, Lemont, PA 16851
(814) 954- 7607, Fax (888) 965-1813

OUTPATIENT SERVICES AGREEMENT and HIPAA PRIVACY POLICY

Welcome to our practice! We are generally open M-F from 9-5 and follow SCASD for weather closings/delays. This document contains important information about our services and policies. It is in place to protect you, as well as the practice. Feel free to ask questions. You will be asked to sign that you have reviewed these documents and agree to receiving treatment.

PSYCHOLOGICAL SERVICES

What to expect: The first session will involve an evaluation of your needs/goals, and at the end of the meeting, you will be presented with some first impressions, as well as a general treatment plan.

Psychotherapy: We want to make therapy a safe, productive place, and we can best do so when you evaluate what is said, consider and share your own opinions, and decide if you feel comfortable with your therapist. After the first session, meetings are generally conducted weekly and reduced in frequency as you improve/make progress. Regular, mutually-agreed upon attendance is expected in order for us to be able to help you. If you miss multiple meetings without letting us know the reason or that you intend to return, your case may be closed. In such situations, we will notify you by phone and/or letter.

Benefits/Risk: Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. It requires an active effort on your part, including time and energy spent in-session and between-session, and it also often involves discussing unpleasant aspects of your life. You may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.

Neuropsychological/Psychological testing: Our goal is to identify what question(s) you want answered by testing and whether or not testing will likely meet your needs, and if so, provide a thorough, accurate assessment of the problem, along with any treatment recommendations which might be of help for you. Doing an initial consultation is not a guarantee that we will recommend that testing be done, as the initial meeting sometimes results in identifying factors for which testing is not appropriate. Actual test items are likely to be challenging, and associated risks include stress or fatigue. For us to be most effective, we recommend that you sign a release to give us permission to communicate with your referring provider. By signing this agreement, you express understanding that we generally give the referring provider a courtesy message regarding your schedule of testing (including if you opt not to pursue testing, as is your right). Your spouse, trusted friend(s) or family are welcomed to attend the initial consultation and feedback, if you wish.

PROFESSIONAL FEES

In order for us to set realistic treatment goals and priorities, it is important for you to evaluate what resources you have available to pay for treatment. Fees are: $200 for the first appointment, $150 for 53+ minute psychotherapy, $125 for 38-52 minute psychotherapy, and $150 per hour of neuropsychological/psychological testing administration, interpretation and report writing.

Regarding testing: Neuropsychological/psychological administration time averages 3-4 hours of in-person, plus 2 hours of test interpretation, and 1 hour of feedback of results. Depending on the date

that writing and interpretation is conducted, the date billed to your insurance may not be a date on which you are in the office. The time used to score tests is provided free, as a courtesy.

Legal involvement: If your therapist is called to testify on your behalf, give a deposition, write letters or have other legal involvement on your behalf, the forensic services fee is $250/hr. Fees are charged by the hour (15 minutes or more charged as an hour, less than 15 minutes not charged). Travel time, court time, documentation time, and other expenses incurred over the course of providing forensic services are likely to be assessed.

If you pay by check and it is bounced back to us, you will be charged a $20 fee, as well as still owe the original amount of the check.

BILLING, PAYMENTS and INSURANCE

Payment is expected at the time of service if you are out-of-network (e.g., Penn State – Aetna) or are paying out-of-pocket. We prefer payment by check, but we can accept cash or credit card. We are able to keep a credit card on file to use to pay for balances owed if you request this. Any overpayments will be refunded in full with a check and mailed to you.

No-shows and excessive late-cancellations (more than 2 per calendar year) also carry a modest fee of $20, which will be strictly enforced. This helps us to defer costs. We reserve the right not to offer you additional services if you have an overdue balance.

If you are using insurance: It is very important that you find out exactly what mental health services your insurance policy covers. You will be responsible for timely payment of any balance not covered by insurance. A list of questions to ask is on our website.

Payments can be made in-person, by mail or through your online account at therapyappointment.com. If you owe a balance at the end of the month, you will receive a bill and will be expected to pay in full upon receipt.

CONTACTING YOUR THERAPIST

Because of the nature of therapy, therapists are often not immediately available by telephone. We try our best to respond within the same day. Please do not use email for emergencies. If you are unable to wait for a return call, it is your responsibility to contact your family physician or the nearest emergency room. There is also a 24-hour help line at 1-800-643-5432, which will also alert us that you have made contact. If your therapist will be unavailable for an extended time, you will be provided with the name of a therapist to contact.

CONFIDENTIALITY

Please see our HIPAA privacy policy. We take privacy seriously. In addition to what is outlined in that document, you should also be aware that ethical practice includes regular case consultation. As such, we may consult with other psychologists about your treatment or engage in supervision. We make every effort to avoid revealing identity, and the consultant/mentor/supervisor is legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless it is relevant. Additionally, as a small business, please know that providers assist each other in various small tasks, such as providing vacation coverage. We also have an administrative assistant who has some access to our records, such as when faxing or receiving information; some clinical information may be shared only as necessary for the purpose of the task at hand.

Our office sponsors undergraduate interns who help with office practices and learn about how a therapy office operates. They are held to the same confidentiality expectations as all therapists. They will, in the process of their internship, have access to limited private information. With your verbal permission, an intern may join an initial consultation or other meeting.

Additionally, we sometimes collect information about your progress in therapy in order to help monitor that we are helping you (e.g., self-report forms). We may use this data, confidentially and with all identifying data removed, in the future to conduct research.

ELECTRONIC COMMUNICATION

Email: Please use your therapyappointment.com account to communicate with us. If you initiate an email with private information to our office through other email, you are giving us permission to respond and understand that it is a security risk. We try to respond to emails within 24 hours during open business hours.

Texting: With your permission, we can send you (and whoever sees your texts) an automated appointment reminder. We do not have the ability to receive personal texts for communication.

Social Media: We have a Facebook site, which you are welcomed to follow if interested. In doing so, you accept that the public can see that you have a Facebook relationship with our business. We will not attempt to contact you via social media, which protects your privacy and the integrity of our work with you.

Website/Web Searches: We have a website that you are free to access for information about the practice. In order to respect your privacy, your therapist will not use web searches to gather information about you unless requested by you. We understand that you might encounter information about your therapist on the web or review your therapist on the web. Please be aware that our code of ethics does not allow us to respond to public comments (such as web healthcare reviews). Your concerns can best be addressed if you talk to us directly, and we welcome this.

PROFESSIONAL RECORDS

The laws and standards of our profession require that treatment records are kept. You are entitled to your records, and we can prepare them or a summary for you, which we recommend be reviewed with you in person. Releasing of records may incur charges, with fees adhering to the State of PA's restrictions on medical records charges. We use an electronic health record system.

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. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, we will provide them only with general information about our work together, unless the therapist feels there is a high risk that you will seriously harm yourself or someone else. In this case, parents will be notified. Parents will also be provided with a summary of your treatment when it is complete. Before giving them any information, your therapist will discuss the matter with you, if possible. We do our best to handle any objections you may have with what has been prepared to discuss.

Ayama Psychotherapy LLC
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NOTICE OF HIPAA POLICY

BACKGROUND: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by congress to help protect health coverage for workers and their families. It also addresses electronic transaction standards and the need to ensure the security and privacy of health data. We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. The security and privacy of your protected health information is the subject of this Privacy Notice.

I. Use and Disclosure of Your Protected Health Information for Treatment, Payment, and Health Care Operations:

We may use or disclose information in your records for **treatment, payment, and health care operations purposes with your consent**.

Personal health information (PHI) refers to information in a client's health record that could identify that client.

Use of this information refers only to activities within this office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure of information refers to activities outside of this office such as releasing, transferring, or providing access to information about you to other parties. Throughout this notice, the term "you" may refer to the individual who is the client or the individual's parent, legal guardian or adult who has been legally determined to be responsible for the client.

In providing for your treatment, we may use or disclose information in your record to help you obtain health care services from another provider, or to assist us in providing for your care. For example, we might consult with another health care provider, such as your physician or another psychologist. In order to obtain payment for services, we may use or disclose information from your record, with your consent. For example, we may submit the appropriate diagnosis to your health insurer to help you obtain reimbursement for your care.

We also may use or disclose information from your record to allow *health care operations* (e.g., quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination).

II. Use and Disclosure Requiring Authorization:

Except as described in this Notice, we may not make any use or disclosure of information from your record for purposes outside of treatment, payment, and health care operations unless you give your written authorization.

You may revoke an authorization in writing at any time, but this will not affect any use or disclosure already completed before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

It is important for you to understand that we cannot control the disclosure of information from your records once your written authorization has been obtained and records have been sent to an outside party. For example, any individual that has obtained your records via your written consent and request (e.g., attorney, other provider) may of their own accord and beyond our control transmit your records to other parties. Please carefully consider the nature of your written consent to disclose any personal documents that originate in our office.

III. Use and Disclosure Without Consent or Authorization:

There are certain circumstances, listed below, in which we are allowed (or, in some cases, required) to use or disclose information from your record without your permission:

• **Child Abuse:** If there is reasonable cause to suspect that a child is or has been abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, or person over the age of fourteen living in the home of the child, the law requires us to report this to the Department of Public Welfare, and/or appropriate governmental agency. The Pennsylvania State Board of Psychology specifically requires that: "psychologists who, in the course of their employment, occupation or practice of their profession, come into contact with children shall report or cause a report to be made to the Department of Public Welfare when they have reasonable cause to suspect on the basis of their professional or other training or experience, that a child coming before them in their professional or official capacity is a victim of child abuse."

• **Adult and Domestic Abuse:** If there is reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we reserve the right to report this to responsible agencies or providers involved with the vulnerable adult (e.g., physician, residential or nursing facility, Office of Aging). Your signature of this form indicates your consent with our right to report elder abuse.

•

• **Driving Risk:** Pennsylvania law specifically requires that healthcare providers report concern about an individual's ability to operate a motor vehicle safely to the medical department of the Pennsylvania Department of Transportation.

• **Judicial or Administrative Proceedings:** Personal Health Information is privileged by

state law. If you are involved in a court proceeding and a request is made for your records, we will not release information without the written authorization of your or your legal representative, including a subpoena. The privilege does not apply if you are being evaluated for a third party, or if the evaluation is court-ordered, or in certain other limited instances. You will be informed in advance if this is the case.

• **Serious Threat to Health or Safety:** If a client presents a clear and immediate probability of physical harm to him or herself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or appropriate authorities.

• **Workers' Compensation and Disability Claims:** If you file a workers' compensation claim or are in the process filing a disability claim, we may disclose information from your record as authorized by applicable laws.

Client's Rights:

• **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected heath information. 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 to have confidential communications of PHI delivered by alternative means and/or at alternative locations. (For example, you may not want a family member to know that you are being seen at this office. Upon your request, we may be able to arrange to 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 our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, given your written request. This may be subject to certain limitations and fees. Upon request, the details of the request process will be discussed with you. Please understand that older records may be destroyed, and therefore no longer available, in accordance with applicable law or standards.

• **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request must be in writing, and we reserve the right to deny your request.

• **Right to an Accounting:** You have the right to request an accounting of certain disclosures that have been made. Upon request, the details of the accounting process will be discussed with you.

• **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from this office upon request, even if you have agreed to receive the notice electronically. Please see www.ayamapsychotherapy.com to review this notice at any time.

• **Right to restrict disclosures associated with marketing:** Disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require client authorization.

• **Right to restrict disclosures associated with out of pocket payment:** Clients have the right to restrict certain disclosures of PHI to health plans or insurance companies if the client pays out of pocket in full for services.

• **Right of notification:** Clients have the right to be notified following a breach of unsecured protected health information.

Psychologist's/Clinician's Duties:

• We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

• We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

• If we make significant revisions to policies and procedures which might affect the privacy of your personal health information, we will provide you with a copy of those revisions. If you are still in treatment at this office, you will be provided with a copy of the revisions in the manner permitted by law, generally by hand delivery at your next appointment. As needed, former clients may be mailed a copy of significant revisions to the most recent mailing address on file at our office. Updated notices of our privacy policies will always be available for review upon request at this office.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact this office in writing or by phone (address and phone number above). We recommend that such inquiries be done in writing.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to our office (address above).

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, or the appropriate administrative office. We can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint, in accordance with the provisions of applicable law.

VI. Effective Date, Restrictions and Changes to Privacy Policy

Restriction: In the case of a minor child, age thirteen and under, the child's legal guardian has the right to inspect or obtain a copy (or both) of PHI in the mental health and billing records

used to make decisions about the child for as long as the PHI is maintained in the record. However, psychotherapy notes including statements made by a child during therapy sessions will not be released, in order to protect the child's right to confidentiality, unless required by law or deemed to be in the best interests of the child.

Restriction: Individuals with legal authorization (Power of Attorney) have the right to inspect or obtain a copy (or both) of PHI in the mental health or billing records used to make decisions about the individual, purpose of evaluation, or purpose of treatment. However, psychotherapy notes and/or written reports will not be released without written documentation of power of attorney that specifies responsibility for health-related issues.

Restriction: This office expressly recommends against the client's use of electronic means of communication. This includes but is not limited to email and social media (e.g., Facebook). We will not initiate electronic communications unless absolutely necessary or no other means exist, and only with your written consent unless this is not possible.

Existing or former clients who decide to initiate electronic communication do so knowing that these communications cannot be protected, and will be discussed with the clinician as an aspect of treatment or evaluation.

Use of our website contact form for changing appointments or other purposes does not require you to include PHI (e.g. state your appointment date and time and our office will contact you).

If other providers or individuals contact this office about you by means of electronic communication (email, texting, etc.) we will not respond without your express written consent. If you anticipate this, please complete a written authorization today.

This notice will go into effect on January 2, 2017. Credit for this HIPAA policy is given to Centre Psychology Group, who created this version.

We are happy to discuss any questions you have. Your signature below indicates that you have read and understand the Outpatient Services agreement and the HIPAA policy for Ayama Psychotherapy LLC. You may keep a copy of the stapled policies if you wish. Your therapist will also sign at the first session. If you wish to have us exchange information with another provider, please complete the Authorization of Release of Information.

_____ _____

Client signature Date

_____

Client printed name

_____ _____

Therapist signature Date

_____

Therapist printed name

Rev. 1/1/19, 6/5/2020 (office policy only)

Ayama Psychotherapy LLC
720 Pike Street, Suite 2, P.O. Box 1122, Lemont, PA 16851
(814) 954- 7607, Fax (888) 965-1813

Elana Szczesny, Ph.D.
Alissa S. Yamasaki, Ph.D.

Authorization for Release of Information

I, _____, D.O.B._____ permit _____
(Name of Client) (Therapist of Ayama)

to receive/provide (circle appropriate) information with _____, located
(Name of Contact)

at _____.
(Address of Contact)

Dates of service to be released: _____ to _____.

Type of information to be exchanged:
☐ Mental Health
☐ HIV/AIDS
☐ Sexually Transmitted Disease
☐ Drug/Alcohol Abuse
☐ General Medical Information
☐ MRI/CT scan
☐ Medical Problem List
☐ Medication List

Specifically:
☐ Progress Notes
☐ Treatment Summary
☐ Psychological Evaluation
☐ Neuropsychological Evaluation
☐ Other_____

For the purpose(s) of:
☐ Scheduling/Billing
☐ Conducting an evaluation
☐ Development of a treatment plan
☐ Treatment coordination
☐ Other (specify):_____

Additionally:
☐ I would like a copy of this release.
☐ I decline a copy, as I know that I can always request a copy.

This release expires on _____ (or 1 year from today if not specified), whichever comes first. I also understand that I can request to revoke the release with a written request. By signing below, I understand that a revocation would not apply to information that has already been released. I also understand that this release is voluntary, and not needed in order to ensure healthcare treatment.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information. Please read it carefully and let me know if you have questions. With your signature, it will represent an agreement between us.

Location During Sessions
All clients must be in the state of PA for telepsychology sessions. By signing this, you agree that no sessions will be conducted while you are out-of-state. This restriction is due to our licensure restrictions.

Benefits/Risks of Telepsychology
Telepsychology refers to providing psychotherapy services remotely via video or telephone, typically for the benefits of continuity of care and convenience. Telepsychology, however, requires technical competence on both of our parts. Here are some risks and differences between in-person psychotherapy and telepsychology:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions. On my end I will take reasonable steps to ensure your privacy. You should do the same, making sure to be in an area where other people cannot overhear.

- Issues related to technology. There are many ways that disruptions can arise with technology, such as it stopping working during a session or other people potentially getting access to our conversation.

- Crisis management/intervention. Telepsychology is not typically used for times of crisis and can be harder to manage than in-person.

- Efficacy. Most research shows that telepsychology is about as effective as in-person therapy, but you should know that there is debate about whether or not something is lost by not being in the same room, such as a therapist's ability to fully read non-verbal information.

Electronic Communications
You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology. We can decide together which mode to use.

Communication between Sessions
As with in-person session, treatment is most effective when clinical discussions occur at your regularly scheduled sessions. If a crisis arises, you can attempt to reach me by phone and I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me or cannot wait for a return call, contact your family physician or the nearest emergency room. You can also contact the 24-hour National Suicide Prevention Lifeline at: 1-800-273-TALK (8255), or the 24-hour Crisis Text Line can be contacted by texting "CONNECT" to 741741 in the United States.

Confidentiality

The extent of confidentiality and its exceptions, as outlined in the Informed Consent document that you were given at the start of therapy, still apply in telepsychology. However, the nature of electronic communications technologies is such that I must warn you that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

Appropriateness of Telepsychology
Periodically, I will consider and check in with you about the appropriateness of using telepsychology with you. I will let you know it becomes a less-appropriate form of treatment.

Technology Disruptions
If you are having an emergency and there is a technical problem, call 911, the 24-hour National Suicide Prevention Lifeline (1-800-273-TALK/8255), or go to your nearest emergency room.

If the session is interrupted under non-emergency circumstances, I will attempt to recontact you via the platform where we were disrupted. If you do not receive a call back within a couple of minutes, then I will call you by phone at the number we have on file.

Fees
The same fee rates will apply for telepsychology as for in-person, but some insurances do not cover teletherapy in the same way that they cover in-person sessions. If your insurance does not cover the service, you will be solely responsible for the full fee of the session. You will be charged a prorated amount of actual session time if there is a technology disruption during a session.

Records
I will maintain a medical record of our session in the same way I maintain records of in-person sessions. The telepsychology sessions shall not be recorded in any manner.

Informed Consent
This agreement is intended as a supplement to the general informed consent used at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____
Name of contact to assist in an emergency Phone of emergency contact

How will you be doing your sessions? ☐Mobile ☐Computer ☐Phone (circle or "x" ONE option)
If using mobile or phone, what number should we use:_____

_____ _____ _____
Client Signature Client Printed Name Date

_____ _____ _____
Therapist Signature Therapist Printed Name Date

Credit Card Authorization Form

Please help us to keep our business running smoothly! Please choose the best option for you. You may cancel this authorization at any time by contacting us, but you will still be held responsible for any services you receive. This authorization will remain in effect until cancelled.

____I, _____, authorize Ayama Psychotherapy LLC to save my most recently used credit card information for any future transactions for agreed upon services. My attendance to a session or class with Ayama Psychotherapy is my indication that it is an agreed upon service.

____I, _____, I agree to pay online on the same day as my services and understand that it is my responsibility to acquire online access if I have lost my login information (email: Jen at Jennifer@ayamapsychotherapy.com to get it reset).

____I, _____, I agree to send in a check on the same day as I receive services (prepayments will be accepted if you wish to just send in a monthly check for ease).

_____ _____
Client Signature Date

_____
Client name printed

720 Pike Street, Suite 2, PO Box 1122, Lemont, PA 16851
Phone: (814) 954-7607 Fax (888) 965-1813
relax@ayamapsychotherapy.com
www.ayamapsychotherapy.com

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 every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

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** _____