# Leader/Group Member Confidentiality

Any information that you reveal to your counselor in group is considered privileged information. It is your right to have that information be kept confidential. Mental health professionals are not allowed to release any information about a client unless a release of information is signed.

There are certain situations in which information about clients may be released with or without permission. These situations are as follows:

1. When children or elderly people are physically abused, sexually abused, or neglected proper authorities will be notified.

2. In emergency situations when there may be danger to the client or others as with suicide, or homicide confidentiality may be broken.

Please read the information carefully and sign below to acknowledge that you received and understood this information.

________________________________________

Name

________________________________________

Date

# Depression Screening Tool

This is a screening measure to help you determine whether you might have depression that needs professional attention. This screening tool is not designed to make a diagnosis of depression but to be shared with your primary care physician or mental health professional to inform further conversations about diagnosis and treatment.

**Over the last two weeks, how often have you been bothered by any of the following problems?**

| | Not at all | Several days | More than half of the days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |

| | Not at all | Several days | More than half of the days | Nearly every day |
|---|---|---|---|---|
| Feeling bad about yourself—or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| Trouble concentrating on things such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| 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 | ☐ | ☐ | ☐ | ☐ |
| Thoughts that you would be better off dead or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |

**If you selected any problems above, how difficult have they 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

# Generalized Anxiety Disorder (GAD) Screening Tool

This is a screening measure to help you determine whether you might have Generalized Anxiety Disorder (GAD) that needs professional attention. This screening tool is not designed to make a diagnosis of GAD but to be shared with your primary care physician or mental health professional to inform further conversations about diagnosis and treatment.

**Are you troubled by the following?**

☐ **Yes** ☐ **No** Do you experience excessive worry?

☐ **Yes** ☐ **No** Is your worry excessive in intensity, frequency, or amount of distress it causes?

☐ **Yes** ☐ **No** Do you find it difficult to control the worry (or stop worrying) once it starts?

☐ **Yes** ☐ **No** Do you worry excessively or uncontrollably about minor things such as being late for an appointment, minor repairs, homework, etc.?

☐ **Yes** ☐ **No** During the last six months, have you been bothered by excessive worries more days than not?

**Please list the most frequent topics about which you worry excessively or uncontrollably:**

---

---

---

**During the past six months, have you often been bothered by any of the following symptoms?**

| | Not at all | | A little | | Moderately | | Quite a bit | | Extremely |
|---|---|---|---|---|---|---|---|---|---|
| Restlessness or feeling keyed up or on edge | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ |
| Irritability | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ |
| Difficulty falling / staying asleep or restless / unsatisfying sleep | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ |
| Easily fatigued | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ |
| Difficulty concentrating or mind going blank | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ |
| Muscle tension | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ |

**How much do worry and physical symptoms interfere with your life, work, social activities, family, etc.?**

| ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ |
|---|---|---|---|---|---|---|---|---|
| None | | Mild | | Moderate | | Severe | | Very Severe |

**How much are you bothered by worry and physical symptoms (how much distress does it cause you)?**

| ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ |
|---|---|---|---|---|---|---|---|---|
| None | | Mild | | Moderate | | Severe | | Very Severe |

Source: Newman, M. G., Zuellig, A. R., Kachin, K. E., Constantino, M. J., Przeworski, A., Erickson, T., & Cashman-McGrath, L. (2002). Preliminary reliability and validity of the Generalized Anxiety Disorder Questionnaire-IV: A revised self-report diagnostic measure of generalized anxiety disorder. *Behavior Therapy*, 33, 215-233. doi:10.1016/S0005-7894(02)80026-0

# Group Member Information

Full Name

Street Address | City | State | Zipcode

Email

Phone

Birthdate

Emergency Contact Name | Phone

How'd you hear about us?

Ethnicity: American Indian | Asian | African-American | Hispanic | White | Other

# Member Behavioral Health History

1. Have you ever been evaluated or diagnosed with a behavioral health issue?

2. Have you ever been evaluated by a psychiatrist and been prescribed any medication(s)?

3. Do you have a good support network of family/friends?

4. Have you experienced any significant life events—deaths, traumas?

5. Have you served in the military?

# Consent to Text and E-mail

I, ________________________________ give my consent to receive electronic communications from my group leader to the e-mail address listed below or via text to the mobile phone number listed below. The consent will remain in effect unless rescinded in writing by myself to Gathering for Groups. A copy of this consent shall be furnished to the member at the time of signing, if requested.

E-mail address: ___________________________________________

Mobile phone for text: ______________________________________

Client Signature: __________________________________ Date: _______________

Client printed name: ________________________________Date: ________________

Group leader signature: ______________________________Date: ________________

# Gathering For Groups HIPPA

You have a right to know Gather for Group's guidelines and procedures regarding your health information, and in most cases to consent to disclose such information to others. By law, your protected health information may be provided without you consent in some criminal investigation or in certain public health and emergency situations. Your protected health information consist of that which we collected in the course of your participating as a group member. Your health information is accessible only to members of the Gathering for Groups staff serving you. Safeguards regarding incidental use and disclosure of protected information within Gathering for Groups has been established. Your protected health information is not part of any other medical record; your physician needs your permission to see your records as does  staff to see your medical records.

You must specifically authorize Gathering for Groups to use or disclose protected health information in most non-routine circumstances. Gathering for Groups does not sell or otherwise provide protected health information to a business that may want to market products or services to you. With your written permission, a copy of all or part of your counseling records may be sent to other counselors, medical staff, or hospitals at no charge. This is only with your permission in an effort to exchange information that would somehow benefit your treatment.

You may request a copy of your records for your personal use. There is a small charge for such copies. You may request corrections of your records subject to preserving the integrity of the documentation of the treatment process. Normally, a review of your treatment records should be done in consultation with a staff member of Gathering for Groups. If you believe that your privacy protections have been violated, you may file a formal complaint with Gathering for Groups. You may also have the right to pursue formal legal action.

This written notice of Gathering for Groups, NFP, privacy practices and your privacy rights is a matter of law. Please acknowledge receipt of this privacy notice by signing the space indicated. A copy of this will be placed in your intake file folder. We reserve the right to change our practices and to make the new provisions effective for all individually identifiable health information we maintain. Should we change our information practices we will mail a revised notice to the address you provided on your intake forms.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices

Signature_________________________________________ Date:____________________________

Printed name: _________________________________________