Sunshine Mental Health
Psychology Services in Powell River, B.C.

STEPHANIE KOVACS, PH.D.
REGISTERED PSYCHOLOGIST
4794 JOYCE AVE. POWELL RIVER, BC V8A-3B6
TEL: (604) 414-7654 FAX: (604) 485-2820
WWW.SUNSHINEMENTALHEALTH.COM

MRN:

CONSENT TO ASSESSMENT

Patient's Name: (print) _____ _____
LAST FIRST

You have been referred for psychological assessment by yourself, physician, or third party insurer. If you have questions about any procedure or test being administered, you are free to ask for an explanation at any time. You may decline to take part in an assessment, procedure, intervention, or homework assignment at your discretion. You may decline to answer any question.

Description of Psychometric Testing:

Psychometric testing is a means of describing human strengths and weaknesses when material is presented in a standardized administration. For this reason, the test administration may seem rather formal and impersonal. Your results will be compared to those of the standardization sample. Standardization is the scientific means of helping researchers and clinicians measure specific qualities about you while minimizing any interference from other qualities. This allows for a clearer picture of your abilities and aids in understanding your specific qualities as compared to other people of similar backgrounds. The test(s) you will complete may help your doctor(s) to know how to better treat you as a unique individual.

Procedures:

Depending on the test(s) that you are asked to complete, you will be asked to perform a specific task. Tasks can range from solving word puzzles, drawing lines, looking at objects, answering direct questions, or even designing things with blocks. Depending on the test(s), your assessment may be as brief as 15 minutes or as long as several hours or days. Please understand for the sake of test security, Dr. Kovacs may not be able to give you much feedback on your performance until all the results are compiled. Some tests are copyrighted and kept under strict privacy. This means that you may not be able to review the specific test items or even your own answers at the completion of the testing without a court order.

Risks or Discomfort:

Many people find the testing procedures interesting and enjoyable. Depending on the test(s) administered, you may develop a mild headache. If this happens, it is quite normal. Psychological assessment involves testing your thinking and perception. By nature of the procedure, you may feel some boredom or fatigue.

Confidentiality:

There are legal and practical limits to confidentiality. For example, if your treatment is paid by a third party provider, they may have the right to request confidential material or require progress reports. A court may order disclosure of records. Administrative staff and the regulatory body of psychologists will have access to information on a need-to-know basis. On occasion, Dr. Kovacs may discuss your case with another psychologist colleague as part of routine practice. These individuals agree to keep material confidential, and any identifying information is withheld or disguised as much as possible. Records will be stored for seven years from the age of majority in a secured location as per requirements set under the Health Professionals Act.

Confidentiality will be legally breeched if you:

- Threaten to harm yourself or are at-risk of incurring serious harm to yourself
- Threaten to harm others or engage in reckless behaviour that is likely to result in serious harm to others
- Disclose neglect, physical, emotional, or sexual abuse of a child, elder, or other vulnerable population
- If you have been told not to drive but continue do so
- Court order

Consent Statement:

I,_____ have been told and understand the limits of confidentiality, risks and benefits of assessment. This statement certifies the following: that I am 19 years of age or older, that I consent to assessment, and all my questions have been answered.

_____ Date: ____/_____/_____
SIGNATURE OF PATIENT / GUARDIAN MM DD YYYY

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FEE AND POLICY AGREEMENT FOR PROVISION OF PSYCHOLOGICAL SERVICES

Patient's Name: (print) _____ _____
LAST FIRST

FEES

I, (please print)_____ agree to contract with Dr. Stephanie Kovacs of Sunshine Mental
FIRST LAST
Health for psychological services on a fee-for-service basis provided at an **hourly rate of $185, consistent with current rates for Registered Psychologists. I understand and agree that the initial visit for assessment or therapy will be billed a one-time fee of $200.**

Patients are responsible for payment of fees at each session or in accordance with the terms listed below. Dr. Kovacs will provide receipts after each session for third party reimbursement. All payment of accounts are ultimately the patient's responsibility.

POLICIES

- **24 hour cancellation policy.** First missed visit billed at half rate.
  All subsequent missed or late-cancels will be billed at full rate. Your insurance may not cover this.
- **Sick –** Please do not come when sick. You will not be penalized. Phone or web sessions are available.
- **Checking In –** Always check in at front desk. Do not use text to announce your arrival.
- **Emergencies –** Dr. Kovacs is not an emergency-responder.
  Appropriate Emergency Resources: 911, hospital, crisis hotline (24/7) 1-800-784-2433.
- **Communication –** Save therapy questions for therapy. Due to volume, Dr. Kovacs is unable to respond to every message but will always try. Missed calls without a voicemail will not be returned.
- **Outside the Office –** To protect your privacy, Dr. Kovacs will always follow your lead if we meet in the community. She will always pretend we have never met unless you decide otherwise. It's best not to discuss your therapy content if we meet in public.
- **Outstanding Payments –** Dr. Kovacs retains the right to charge 1.5% interest compounded monthly on balances outstanding beyond 90 days. By signing below, you understand that if the balance is based on a running account, 1.5% interest will be compounded monthly on the cumulative balance after the first 90 days of this signature. You further acknowledge and approve of Dr. Kovacs sending unpaid balances after 1 year of your last appointment to a collection service.
- **Letters/Forms Rates –** Billed by the hour. 15-30 mins ($92.50)
- **Hardcopy Fees –** 50 cents / page if 25pgs or less. 25 cents / page if >25pgs.

I have read and understand the above fee agreement and policies for provision of psychological services. My signature below indicates that I understand this agreement and hereby agree to the terms and conditions stated herein.

_____ Date: ____/_____/_____
SIGNATURE OF PATIENT / GUARDIAN MM DD YYYY

Relationship to patient (if applicable): _____

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ADULT HISTORY

PLEASE PRINT

The information your provide is strictly confidential and will be used only to aid in your care. Exceptions to confidentiality discussed in your first visit also apply to the information on this form. If you feel uncomfortable answering any item, please leave it blank and discuss with Dr. Kovacs.

PERSONAL INFORMATION

_____ _____ _____
FIRST NAME LAST NAME MI

DATE OF BIRTH: _____ _____ _____ _____
MONTH DAY YEAR AGE

_____ _____ _____
GENDER: RACE/ETHNICITY BIRTHPLACE

CONTACT INFORMATION

_____ _____ _____ _____
STREET ADDRESS CITY PROV POSTAL

HOME PH: ____ - _____ - _____ OK TO LEAVE VOICEMAIL? ___Y ___N
CELL PH: ____ - _____ - _____ OK TO LEAVE VOICEMAIL? ___Y ___N TEXT? __Y __N
WORK PH: ____ - _____ - _____ OK TO LEAVE VOICEMAIL? ___Y ___N
EMAIL ADDRESS: _____

EMERGENCY CONTACT:

FIRST NAME: _____ **LAST NAME:** _____
HOME PH: _____ **CELL PH:** _____ **WORK PH:** _____
RELATION TO PATIENT: _____

OCCUPATIONAL INFORMATION

EMPLOYMENT STATUS: €FULL-TIME? €PART-TIME? € UNEMPLOYED? € RETIRED?
CURRENT OCCUPATION: _____
COMPANY NAME: _____
#YEARS WITH COMPANY: _____

HIGHEST LEVEL OF EDUCATION: _____

_____ _____
DEGREE/CERTIFICATE TITLE: INSTITUTION:

_____
YEAR GRADUATED

SOCIAL INFORMATION

RELATIONSHIP STATUS: _____
SPOUSE/PARTNER NAME (IF APPLICABLE):_____
PARTNER AGE: _____ #YEARS TOGETHER: _____

LIST CHILDREN, THEIR NAMES, AND ANY SIGNIFICANT PROBLEMS:

_____
_____
_____

RELIGION: _____
HOW IMPORTANT IS RELIGION/SPIRITUALITY TO YOU? _____

LIST ALL MEMBERS OF HOUSEHOLD AND THEIR RELATIONSHIP TO YOU:

_____
_____

ANY CURRENT FINANCIAL STRESS:

IN GENERAL, HOW WOULD YOU DESCRIBE THE WAY YOU GET ALONG WITH PEOPLE?

HOW MANY CLOSE FRIENDS AND FAMILY MEMBERS CAN YOU RELY ON? _____

PLEASE DESCRIBE YOUR SOCIAL SUPPORT NETWORK:

DESCRIBE ANY RELATIONSHIP PROBLEMS:

DESCRIBE ANY PROBLEMS WITH REGARDS TO SEX:

MEDICAL HISTORY

DOCTOR'S NAME:_____

CURRENT PRESCRIPTIONS:

_____

_____

_____

PAST PRESCRIPTIONS:

_____

_____

_____

SIGNIFICANT HEALTH HISTORY OR CONDITIONS:

SUBSTANCE USE

CURRENT MONTHLY OR YEARLY USE

_____

_____

PAST:

_____

_____

LIST ANY EXPERIENCES WITH DRUG REHAB PROGRAMS OR CURRENT RECOVERY GROUPS:

_____

_____

LEGAL HISTORY

LIST ANY CRIMINAL CHARGES OR OPEN LEGAL DISPUTES:

LIFESTYLE

PLEASE DESCRIBE YOUR CURRENT LEVEL OF PHYSICAL ACTIVITY: (Eg., sports, activities, exercise, etc.)

PLEASE DESCRIBE YOUR CURRENT DIET / EATING HABITS: (Eg. vegan, low sodium, excessive eating when stressed; lack of appetite, repetitive dieting, etc.)

PLEASE DESCRIBE ANY PROBLEMS WITH SLEEP:

PSYCHOLOGICAL HISTORY

PREVIOUS COUNSELLING? (LIST NAMES, DATES, AND THE PRIMARY PROBLEMS):

EG., DR. SUSAN SMITH 2010-2012 DEPRESSION

_____

_____

PREVIOUS HOSPITALIZATIONS FOR PSYCHIATRIC PROBLEMS?

_____

_____

PREVIOUS TESTING / ASSESSMENTS?

_____

_____

FAMILY MENTAL HEALTH HISTORY (*EG, MOTHER (DEPRESSION))*

MATERNAL SIDE _____

_____

PATERNAL SIDE _____

_____

HAVE YOU EVER CONTEMPLATED SUICIDE OR HURINT YOURSELF? PLEASE SHARE

DO YOU CURRENTLY HAVE ANY SUICIDAL IDEAS? IF SO, PLEASE EXPLAIN:

PLEASE DESCRIBE ANY PROBLEMS YOU MIGHT HAVE HAD IN CHILDHOOD OR ADOLESCENCE:

HAVE YOU EVER EXPERIENCED A SERIOUS TRAUMA? IF SO, PLEASE EXPLAIN:

TELL ABOUT ANY PROBLEMS WITH DEPRESSION:

TELL ABOUT ANY PROBLEMS WITH ANXIETY:

TELL ABOUT ANY PROBLEMS WITH ANGER/AGGRESSION:

HOW DO YOU EXPLAIN WHAT IS GOING ON IN YOUR LIFE?

WHAT ARE YOUR EXPECTATIONS FOR THERAPY? WHAT SPECIFIC GOALS WOULD YOU LIKE TO ADVANCE?

ANY OTHER IMPORTANT INFORMATION?

WHO REFERRED YOU TO SUNSHINE MENTAL HEALTH?

_____

DASS 21

NAME _____ DATE _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time – SOMETIMES

2 Applied to me to a considerable degree, or a good part of time – OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

		Select 0 1 2 3	FOR OFFICE USE D	A	S
1.	I found it hard to wind down				
2.	I was aware of dryness of my mouth				
3.	I couldn't seem to experience any positive feeling at all				
4.	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)				
5.	I found it difficult to work up the initiative to do things				
6.	I tended to over-react to situations				
7.	I experienced trembling (eg, in the hands)				
8.	I felt that I was using a lot of nervous energy				
9.	I was worried about situations in which I might panic and make a fool of myself				
10.	I felt that I had nothing to look forward to				
11.	I found myself getting agitated				
12.	I found it difficult to relax				
13.	I felt down-hearted and blue				
14.	I was intolerant of anything that kept me from getting on with what I was doing				
15.	I felt I was close to panic				
16.	I was unable to become enthusiastic about anything				
17.	I felt I wasn't worth much as a person				
18.	I felt that I was rather touchy				
19.	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)				
20.	I felt scared without any good reason				
21.	I felt that life was meaningless				
		TOTALS	0	0	0

DASS Severity Ratings

The DASS is a **quantitative** measure of distress along the 3 axes of depression, anxiety[1] and stress[2]. It is not a categorical measure of clinical diagnoses.

Emotional syndromes like depression and anxiety are intrinsically dimensional - they vary along a continuum of severity (independent of the specific diagnosis). Hence the selection of a single cut-off score to represent clinical severity is necessarily arbitrary. A scale such as the DASS can lead to a useful assessment of **disturbance**, for example individuals who may fall short of a clinical cut-off for a specific diagnosis can be correctly recognised as experiencing considerable symptoms and as being at high risk of further problems.

However for clinical purposes it can be helpful to have 'labels' to characterise degree of severity relative to the population. Thus the following cut-off scores have been developed for defining mild/moderate/severe/ extremely severe scores for each DASS scale.

Note: the severity labels are used to describe the full range of scores in the population, so 'mild' for example means that the person is above the population mean but probably still way below the typical severity of someone seeking help (ie it does not mean a mild level of disorder.

The individual DASS scores do not define appropriate interventions. They should be used in conjunction with all clinical information available to you in determining appropriate treatment for any individual.

[1]Symptoms of psychological arousal

[2]The more cognitive, subjective symptoms of anxiety

DASS 21 SCORE

DEPRESSION SCORE	ANXIETY SCORE	STRESS SCORE
0	0	0

	Depression	Anxiety	Stress
Normal	0 - 4	0 - 3	0 - 7
Mild	5 - 6	4 - 5	8 - 9
Moderate	7 - 10	6 - 7	10 - 12
Severe	11 - 13	8 - 9	13 - 16
Extremely Severe	14 +	10 +	17 +