Tandra T, Baker, Tapestry of Wellness, LLC
LPC-MH, LAC, QMHP & Linehan Board Certified DBT Clinician

PATIENT REGISTRATION SHEET

Today's Date: | Please Print

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address:	City:	State:		ZIP Code:
Home phone #: ( )	Cell/Other contact #: ( )	Social Security #:	Birth Date: / /	Sex: ❑ M ❑ F
Email:				
Employer:	Occupation:	Work phone #: ( )		
Street Address:	City:	State:		ZIP Code:
Referring Doctor (if required by insurance):				
Notify Primary Care Physician? ❑ YES ❑ NO	Name of Primary Care Physician	Contact #: ( )		

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone #: ( )	Cell phone #: ( )

INSURANCE INFORMATION

Insured's Last Name **(if different):**	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone #: **(if different)** ( )	Cell/Other contact #: ( )	Social Security #:	Birth Date: / /	Sex: ❑ M ❑ F
Insurance Company:	Insurance Billing Address:		Insurance phone #: ( )	
Policy #:	Group #:	Relationship to Insured:	❑ Self ❑ Spouse ❑ Dependent	

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company:	Insurance Billing Address:		Insurance phone #: ( )	
Policy #:	Group #:	Relationship to Insured:	❑ Self ❑ Spouse ❑ Dependent	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. *I understand that I am financially responsible for any balance.* I also authorize Tandra T. Baker, Tapestry of Wellness, LLC & those acting on her behalf, and my insurance company to release any information required to process my claims.

Right to Refuse Treatment: I understand that I have the right to refuse any treatment.
Confidentiality: I understand that all information concerning me is held in confidence and can only be released with my written permission, with the following exceptions: my therapist is legally required to report to designated authorities when it is believed someone is a danger to themselves or others, including child/elder abuse/neglect, or as required by federal or state law. Your therapist may be involved in case consultation within DBT Teams and Midwest Health Management Services as needed.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

Patient/Guardian signature *Date*

*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations.***
*** Otherwise, your account will be charged the full fee for the session time. Thank you for your cooperation. ***

Tandra T. Baker, Tapestry of Wellness, LLC
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5708 S. Remington Place, Suite 400
Sioux Falls, SD 57108
Tel: 605-530-2968

Intake Information

Client Name: _____ **Date:** _____

Check which of the following you have had in the past 6 months:

- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Depressed Mood
- ☐ Suicidal thoughts
- ☐ Suicide attempt
- ☐ Fear
- ☐ Decreased Sleep
- ☐ Increased Sleep
- ☐ Relationship concerns
- ☐ Anger
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Increased alcohol consumption
- ☐ Racing thoughts
- ☐ Delusions
- ☐ Hallucinations
- ☐ Hopelessness
- ☐ Increased energy
- ☐ Trauma
- ☐ Loss
- ☐ Inability to focus
- ☐ Medical concerns
- ☐ Self-harming
- ☐ Tearfulness
- ☐ Legal problems
- ☐ Other _____

Briefly describe why you are seeking help at this time?

_____

_____

_____

Have you had any previous counseling? Y ____ N _____

If yes, who? _____

Name **Phone Number**

May we contact them? Y _____ N _____ (additional Release of Information needed to contact)

Describe any current or recurrent health problems you or your family may have?

_____

_____

List all medications in use (name, dosage, frequency, who prescribes them):

_____

_____

Any other information you would like the therapist to know:

_____

_____

_____

What is your general goal for counseling?

_____

_____

_____

Who referred you? _____

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Financial Policy

Thank you for choosing me your health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. If you are uncertain of the cost for a specific service, you are encouraged to inquire about this. Please know that it is your responsibility to contact your insurance company and to know the benefits that you have under your policy.

Fees:

Payment /Co-pay is due at The Time of Service.

- **With Health Insurance**
  - Diagnostic Assessment (up to three sessions) - $250
  - Individual Sessions - $110 (16-37 min); $145 (38-52 min); $200 (53-60 min)
  - Family/Couples Sessions – $200 (53-60 min)
  - DBT Group Sessions - $80 (75-90 min)
  - Family Therapy (With or Without Client Present) - $200
- **Without Health Insurance – MEDICARE and/or MEDICAID is not accepted**

  Cash Fee:
  - Diagnostic Assessment (up to three sessions) - $200
  - Individual & Family/Couples Sessions - $170
  - DBT Group Sessions - $75
  - No Show Appointment & Late Cancellation Fee - $170
  - No Show Fee for DBT Group - $75
  - HPAP Meeting On Site/Missed Session - $45
  - Court Prep Fee - $350/hour *(pre-payment required)*
  - Court Testimony Fee - $400/hour *(pre-payment required)*

Payments:

- Cash, Checks, Visa, Mastercard or Discover Card are accepted
- Payment is due at the time of service
- For personal checks that are written and returned there will a $40 charge added to your bill. If a check is returned twice, a check will no longer be accepted

I, the undersigned client, hereby knowingly and with full understanding state that I am covered under insurance and agree to pay the agreed amount at the time of each visit for services received by Tandra T. Baker, Tapestry of Wellness, LLC, LPC-MH, LAC, QMHP. I understand that this amount is a good faith estimate of the client obligation but is not necessarily the amount owed by me. I further understand that this amount will be applied to any amounts owed for service rendered by Tandra T. Baker, Tapestry of Wellness, LLC, LPC-MH, QMHP, LAC, and that it is not total or final payment on my bill. After insurance processes my claim, and my portion is clearly defined, I will be billed for the difference of what my insurance plan processes as my portion, less the above referenced amounts paid at the time of service. If insurance does not cover services I agree that I am fully responsible for payment.

I have read, completely understand and agree to the above policy and the fees set for the counseling sessions.

Patient Signature: _____ Date: _____

Printed Name: _____

Therapist Signature: _____ Date: _____

Tandra T. Baker, LPC-MH, LAC, QMHP

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Card Payment Agreement

Client Name: _____ **Date:** _____

Credit Card Type	
Credit Card Number	
Expiration Date	
3 or 4 digit Security Code	
Name on Card	
Zip Code	

I agree that my card will be charged the following amounts after each scheduled session and/or No Show/Late Cancellation.

Cash Fee Other: _____
Deductible Amount: _____ **Co-Pay:** _____

- **Intake:** _____
- **Individual Session:** _____
- **Group Session:** _____
- **No Show/Less than 24 hour Notice of Cancellation: Individual $170: DBT Group $75: HPAP Meeting Full Fee. THERE ARE NO EXCEPTIONS**

I agree to allow ***Tandra T Baker, Tapestry of Wellness, LLC, LPC-MH, LAC, QMHP*** to charge the card listed above for the purpose of payment. I agree that if my card expires I will supply my updated card information. I also identify that my card will be charged for all charges unless ***Tandra T Baker, Tapestry of Wellness, LLC, LPC-MH, LAC, QMHP*** is notified in writing to stop making charges to this credit card and an alternative form of payment is established.

I agree to all the above terms and conditions.

Signed: _____ Date: _____

Tapestry of Wellness, LLC
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Release Authorization Form

I, _____, whose Date of Birth is _____, authorize *Tandra T. Baker, Tapestry of Wellness, LLC, LPC-MH, QMHP, LAC* to disclose to and/or obtain the following information from:

_____

[Name of Person or Title of Person or Organization]

Description of Information to be Disclosed:

_____ Assessment
_____ Psychosocial Evaluation
_____ Treatment Plan/Summary
_____ Presence/Participation in Treatment
_____ Demographic Information
_____ Psychological Evaluation
_____ Continuing Care Plan
_____ Alcohol & Drug Use Evaluation
_____ Progress in Treatment
_____ Mutually Unrestricted
_____ Diagnosis
_____ Other

Purpose:
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:_____

Revocation:
I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Tandra T. Baker, Tapestry of Wellness, LLC, 5708 S. Remington Place, Suite 400, Sioux Falls, SD 57108. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:
Unless sooner revoked, this consent expires in one year from the signed date, or as otherwise indicated:
_____

Conditions:
I further understand that *Tandra T. Baker, Tapestry of Wellness, LLC,* will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
_____

Form of Disclosure:
Unless you have specifically requested in writing that the disclosure be made in certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure:
Federal law prohibits this person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

_____

Signature of Patient/Client/Guardian **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual) power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

_____

Tandra T Baker, MA, LPC-MH, LAC, QMHP **Date**

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NAME: _____ **DATE:** _____

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you *think you might have felt*. Please answer honestly. **All questions refer to the last week. If you felt different ways at different times in the week, give a rating for how things were for you on average. Please be sure to answer each question.**

In the course of last week...		not at all	a little	rather	much	very strong
1	It was hard for me to concentrate	0	1	2	3	4
2	I felt helpless	0	1	2	3	4
3	I was absent-minded and unable to remember what I was actually doing	0	1	2	3	4
4	I felt disgust	0	1	2	3	4
5	I thought of hurting myself	0	1	2	3	4
6	I didn't trust other people	0	1	2	3	4
7	I didn't believe in my right to live	0	1	2	3	4
8	I was lonely	0	1	2	3	4
9	I experienced stressful inner tension	0	1	2	3	4
10	I had images that I was very much afraid of	0	1	2	3	4
11	I hated myself	0	1	2	3	4
12	I wanted to punish myself	0	1	2	3	4
13	I suffered from shame	0	1	2	3	4
14	My mood rapidly cycled in terms of anxiety, anger, and depression	0	1	2	3	4
15	I suffered from voices and noises from inside or outside my head	0	1	2	3	4
16	Criticism had a devastating effect on me	0	1	2	3	4
17	I felt vulnerable	0	1	2	3	4
18	The idea of death had a certain fascination for me	0	1	2	3	4
19	Everything seemed senseless to me	0	1	2	3	4
20	I was afraid of losing control	0	1	2	3	4
21	I felt disgusted by myself	0	1	2	3	4
22	I felt as if I was far away from myself	0	1	2	3	4
23	I felt worthless	0	1	2	3	4

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Now we would like to know in addition the quality of your **overall** personal state in the course of the last week. 0% means **absolutely down**, 100% means **excellent**. Please check the percentage which comes closest.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
(very bad)	◄								►	(excellent)

BSL - Supplement: Items for Assessing Behavior

	During the last week.....	Not at all	once	2-3 times	4-6 times	Daily or more often
1	I hurt myself by cutting, burning, strangling, headbanging etc.	0	1	2	3	4
2	I told other people that I was going to kill myself	0	1	2	3	4
3	I tried to commit suicide	0	1	2	3	4
4	I had episodes of binge eating	0	1	2	3	4
5	I induced vomiting	0	1	2	3	4
6	I displayed high-risk behavior by knowingly driving too fast, running around on the roofs of high buildings, balancing on bridges, etc.	0	1	2	3	4
7	I got drunk	0	1	2	3	4
8	I took drugs	0	1	2	3	4
9	I took medication that had not been prescribed or if had been prescribed, I took more than the prescribed dose	0	1	2	3	4
10	I had outbreaks of uncontrolled anger or physically attacked others	0	1	2	3	4
11	I had uncontrollable sexual encounters of which I was later ashamed or which made me angry.	0	1	2	3	4

Please double-check for missing answers

WE THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

PLEASE RETURN THE QUESTIONNAIRE TO YOUR THERAPIST

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Name: _____ **Date:** _____

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question

		Yes	No
1.	Have you used drugs other than those required for medical reasons?		
2.	Have you abused prescription drugs?		
3.	Do you abuse more than one drug at a time?		
4.	Can you get through the week without using drugs (other than those required for medical reasons)?		
5.	Are you always able to stop using drugs when you want to?		
6.	Do you abuse drugs on a continuous basis?		
7.	Do you try to limit your drug use to certain situations?		
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?		
9.	Do you ever feel bad about your drug abuse?		
10.	Does your spouse (or parents) ever complain about your involvement with drugs?		
11.	Do your friends or relatives know or suspect you abuse drugs?		
12.	Has drug abuse ever created problems between you and your spouse?		
13.	Has any family member ever sought help for problems related to your drug use?		
14.	Have you ever lost friends because of your use of drugs?		

		Yes	No
15.	Have you ever neglected your family or missed work because of your use of drugs?		
16.	Have you ever been in trouble at work because of drug abuse?		
17.	Have you ever lost a job because of drug abuse?		
18.	Have you gotten into fights when under the influence of drugs?		
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20.	Have you ever been arrested for driving while under the influence of drugs?		
21.	Have you engaged in illegal activities in order to obtain drug?		
22.	Have you ever been arrested for possession of illegal drugs?		
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?		
25.	Have you ever gone to anyone for help for a drug problem?		
26.	Have you ever been in a hospital for medical problems related to your drug use?		
27.	Have you ever been involved in a treatment program specifically related to drug use?		
28.	Have you been treated as an outpatient for problems related to drug abuse?		

Office Use Only: Code: _____

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Name: _____ **Date:** _____

The Michigan Alcohol Screening Test (MAST)

Directions: read each question carefully and answer yes or no to the following questions:

1. Do you feel you are a normal drinker? ("normal" is defined as drinking as much or less than most other people)
___ Yes ___ No

2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?
___ Yes ___ No

3. Does any near relative or close friend ever worry or complain about your drinking?
___ Yes ___ No

4. Can you stop drinking without difficulty after one or two drinks?
___ Yes ___ No

5. Do you ever feel guilty about your drinking?
___ Yes ___ No

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
___ Yes ___ No

7. Have you ever gotten into physical fights when drinking?
___ Yes ___ No

8. Has drinking ever created problems between you and a near relative or close friend?
___ Yes ___ No

9. Has any family member or close friend gone to anyone for help about your drinking?
___ Yes ___ No

10. Have you ever lost friends because of your drinking?
___ Yes ___ No

11. Have you ever gotten into trouble at work because of drinking?
___ Yes ___ No

12. Have you ever lost a job because of drinking?
___ Yes ___ No

13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking?
___ Yes ___ No

14. Do you drink before noon fairly often?
___ Yes ___ No

15. Have you ever been told you have liver trouble, such as cirrhosis?
___ Yes ___ No

16. After heavy drinking, have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?
___ Yes ___ No

17. Have you ever gone to anyone for help about your drinking?
___ Yes ___ No

18. Have you ever been hospitalized because of drinking?
___ Yes ___ No

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
___ Yes ___ No

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem?
___ Yes ___ No

21. Have you been arrested more than once for driving under the influence of alcohol?
___ Yes ___ No

22. Have you ever been arrested, or detained by an official for a few hours, because of other behavior while drinking?
___ Yes ___ No

For Office Use Only: Code: _____

PSS-I-5

Name: _____ **Date:** _____

TRAUMA SCREEN

Many people are exposed to a disturbing or traumatic event at some point in their lives. These experiences can happen in any of the following ways:

1. Directly experiencing the event
2. Witnessing the event
3. Learning that the event happened to a close family member or close friend
4. Experiencing repeated or intense exposure to distressing details of the event (e.g. emergency workers collecting human remains)

Examples of traumatic events include: natural disasters, accidents, sexual assaults, physical assaults, combat, childhood sexual abuse torture, or life-threatening illness.

Have you experienced such an event?
____Yes
____No

Please briefly describe the experience which is the **most distressing and the most haunting for you currently**.

If you are unsure, briefly describe the experience anyway:

_____

_____

_____

_____

Did this event included:

a. Actual or threatened death? Yes No
b. Actual or threatened serious injury? Yes No
c. Actual or threatened sexual violation Yes No

When did this event occur? _____

PSS-I-5

Questions should be about the most currently distressing trauma. Each item below should be asked in reference to the past month (if < 1 month since trauma, ask "Since the event..."). Probe all positive responses (e.g., "How often has this been happening?") following the instructions provided in the PSS-I-5 manual.

0		2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

RE-EXPERIENCING (need one): [probe, then quantify]

1. Have you had unwanted distressing memories about the trauma?
2. Have you been having bad dreams or nightmares related to the trauma?
3. Have you had the experience of feeling as if the trauma were actually happening again?
4. Have you been very EMOTIONALLY upset when reminded of the trauma?
5. Have you had PHYSICAL reactions when reminded of the trauma (e.g., sweating, heart racing)?

AVOIDANCE (Need one): [probe, then qualify]

6. Have you been making efforts to avoid thoughts or feelings related to the trauma?
7. Have you been making efforts to avoid activities, situations, or places that remind you of the trauma or that feel more dangerous since the trauma?

CHANGES IN COGNITION AND MOOD (Need two): [probe, then qualify]

8. Are there any important parts of the trauma that you cannot remember?
9. Have you been viewing yourself, others, or the world in a more negative way (e.g."I can't trust people," "I'm a weak person")?
10. Have you blamed yourself for the trauma or for what happened afterwards? Have you blamed others that did not directly cause the event for the trauma or what happened afterwards?
11. Have you had intense negative feelings such as fear, horror, anger, guilt or shame?
12. Have you lost interest in activities you used to do?
13. Have you felt detached or cut off from others?
14. Have you had difficulty experiencing positive feelings?

0		2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

INCREASED AROUSAL AND REACTIVITY (need two): [probe then quantify]

15. Have you been acting more irritable or aggressive?

16. Have you been taking more risks or doing things that might cause you or others harm (e.g., driving recklessly, taking drugs, having unprotected sex)?

17. Have you been overly alert or on-guard (e.g., checking to see who is around you, etc.)?

18. Have you been jumpier or more easily startled?

19. Have you had difficulty concentrating?

20. Have you had difficulty falling or staying asleep?

TOTAL SCORE (add items 1-20) =_____

DISTRESS AND INTERFERENCE

21. How much have these difficulties been bothering you?

22. How much have these difficulties been interfering with your everyday life (e.g. relationships, work, or other important activities)?

SYMPTOM ONSET AND DURATION

23. How long after the trauma did these difficulties begin? [circle one]
    a. Less than 6 months
    b. More than 6 months

24. How long have you had these trauma-related difficulties? [circle one]
    a. Less than 1 month
    b. More than 1 month