Texas Military Department Counseling Program

Informed Consent for Treatment

*This intake packet (informed consent, biopsychosocial, and screener forms) ***must*** be completed and returned to Counselor ***24 hours prior*** to your scheduled session in order to commence treatment

Overview: The Texas Military Department (TMD) Counseling Program provides clinical services to Texas National and State Guard Service Members (SM). The TMD Counselors are independently licensed by state licensure boards to provide professional mental health services. Clinical services may include counseling, assessment, diagnosis, goal setting, crisis management, referral, case management and/or consultation. Services may be offered in an office, public venue, or by Telehealth. Telehealth services include video conferencing and telephone calls.

Attendance Policies: Appointments typically last for a "therapeutic hour" of 50-60 minutes. When we schedule an appointment, that time is reserved specifically for you and prompt attendance for all scheduled appointments is considered important to the successful course of counseling. If there is a need to cancel or reschedule an appointment, we ask that you give at least **24 hours'** notice. If there are **two** instances of failure to provide sufficient notice or arrival to session is 15 minutes or more late, please be aware that this could result in termination from TMD Counseling Program services.

The Counseling Process, Benefits and Risks: Effective counseling can improve your ability to handle or cope with marital, family, and other interpersonal concerns while enhancing your own awareness of personal needs, feelings, and goals. Additional benefits of counseling may include, but are not limited to increased maturity, improved self-esteem, reduced symptoms, and increased personal fulfillment. In working to achieve these potential benefits, however, counseling may require you to make efforts to change, remember unpleasant events, and at times lead to significant emotional discomfort. It is important to realize that sometimes relieving distress means temporarily increasing distress. Please inform your counselor of such experiences so that he or she is aware and can help you to manage the process. Regarding legal or forensic-related requests for treatment, the TMD Counseling Program does not provide any type of forensic counseling services. In the event of legal or related proceedings, including those related to divorce or child-custody, the TMD Counseling Program will only release information with a judge-signed court order. Additionally, the TMD Counseling Program does not complete certain documentation or evaluations, such as but not limited to VA claims, military separation, or determination of fitness for duty.

Termination and Continuation of Care: TMD Counseling services are voluntary and generally intended for short-term treatment, about 6 months or less unless determined clinically necessary to continue care. Services may be utilized more than once. However, if the cumulative treatment time surpasses one year, then referral to an outside provider for continued care may be discussed with your counselor. Both you and your counselor reserve the right to transfer/terminate services at any time. Such reasons may include but are not limited to treatment goals being achieved, TMD Counseling Program is unable to appropriately meet the client's needs, or client does not adhere to responsibilities outlined in this consent. Upon termination of services, counselor will attempt to facilitate aftercare recommendations and referrals to external providers if needed. Even after terminating services, access to the 24/7 Counseling Line at (512)782-5069 remains available to you while you are in the Texas National and State Guard.

Therapeutic Relationship and Contact Outside of the Office: The client-counselor relationship is a purely professional one and rooted in mutual respect, in which appropriate boundaries are maintained despite the potential for close emotional bonds to develop over the course of treatment. As such, your counselor cannot be involved in a social relationship with you. Additionally, we will not accept invitations to weddings, birthdays, social media accounts, etc. If we run into each other in the community, we typically will not acknowledge you to maintain confidentiality. Because TMD Counselors' offices are placed within military installations, we may often cross paths with you at work. In those cases, we may choose to acknowledge you by rank or professional job title but will not publicly disclose your participation in counseling services.

Notice of Privacy Practices: The TMD Counseling Program is committed to keeping medical, mental health, and substance use records protected and confidential under state and federal laws, regulations, and ethical mandates (including, but not limited to, 5 U.S.C. 7361, 7362, 7901, and 7904, 44 U.S.C. 3101, and the Privacy Act of 1974). This notice is being provided to you as a requirement of the Texas Health and Safety Code, Title 7., Subtitle E., Chapter 611. Mental Health Records; the Health Insurance Portability and Accountability Act (HIPAA) 42 U.S.C. §1320d et seq., 45 C.F.R. Parts 160 & 164; and the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 U.S.C. § 290dd-2, 42 CFR Part 2 ("Part 2"). We reserve the right to change the terms of this notice, will post the revised notice, and at your request will give you a copy of the revised notice. The new notice would be effective for any health information held at that time or received after that time.

Your Rights Regarding Your Health Information

- Confidential Communications: You may ask that we communicate with you in a particular way, such as calling you at work rather than at home, to maintain your confidentiality. Electronic communications such as email, text, or Telehealth platforms may not be secure. We cannot guarantee privacy, HIPAA compliance, or protection against interception by unauthorized

parties. Email and text may also be considered part of your medical record

- Record Keeping: Client records are required to be kept for a minimum of seven (7) years after the date of termination of services with an adult client or five (5) years after a minority client reaches the age of 18 years, whichever is greater in duration.
- Minor's Records: The relevant parent or legal guardian of non-emancipated minor clients may also have the right to access the clients' records.
- Requesting Records: Client records are maintained by the TMD Counseling Program and not property of individual counselors. In the event of the counselor's death, incapacity or termination from TMD employment, the client's records remain within TMD Counseling. You have the right to review or receive a copy of the information in your record. To request your records, submit a written request to the custodian of records at ng.tx.ng-sg.mbx.tmd-counseling@army.mil. Once you have completed a Release of Information and submitted this written request, the custodian of records has up to 15 calendar days to provide your requested information. Under limited circumstances we may deny access to the record, or portions of the record (for instance, if disclosing the information would endanger you or someone else); you may submit a written request for a review of that decision.
- Requesting Addendum: You have the right to request that we amend the records by submitting a request in writing that provides your reason for requesting the amendment. We may deny your request to amend a record; you may submit a written request for a review of that decision.
- Requesting Restrictions: You may request, in writing, that we limit our use or disclosure of your health information. We are not required to agree to your request, but if we do agree to it, we will honor your request except when specifically authorized by you, when required by law or in an emergency.

How We Will Use and Disclose Your Health Information

Disclosure of records shall be prohibited except with the written consent of the SM or as otherwise authorized by law. When the SM gives prior written consent to release information, this release specifically indicates the nature and scope of topics to be released, to whom information is to be released, the purpose of the disclosure, and the date on which the consent terminates. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision. We may use or disclose healthcare information about you ***without*** your prior authorization for other certain situations per state, federal and Department of Defense requirements. Possible exceptions that mandate release of information are as follows:

- For suspicion of child, vulnerable adult or elder abuse or neglect.
- If a client poses a danger to self or others.
- The disclosure is made to medical personnel in a medical emergency.
- For program case consultation, audit or evaluation, operations and/or reporting treatment outcomes with minimal PHI.
- If client discloses that sexual exploitation by a mental health services provider has occurred.
- In connection with lawsuits or other legal proceedings in response to a valid judge-signed court order.

Service Member Requirement for Self-Reporting

SMs may be required or mandated to self-report information to a military health care provider or commander. The SM is responsible for determining their need to self-report. The TMD Counselors are not mandated to notify command of any information disclosed by SM. However, you have the option to provide someone in your chain of Command as an emergency contact if/when a mental health or medical emergency arises in session.

☐ I do not consent to provide my Command information.

☐ I consent to provide my Command information as an emergency contact. If yes, list command contact information (rank, name, and phone number): _____

Treatment Including Minors: Treatment including a non-emancipated child under the age of 18 will only be provided with the permission of a legal guardian or conservator. It is required by our State Licensing board that we keep a copy of the current divorce decree or custody order stating who has the authority for making mental health decisions for the minor. Therefore, we must receive a copy of the relevant documentation prior to beginning family counseling. If more than one parent has legal authority to make mental health decisions for the minor written consent must be obtained by *both legal guardians* before beginning treatment.

Telehealth Service Considerations:

1. There can be partial or complete failure of equipment.
2. No permanent video or voice recording is kept of the Telehealth Services session.
3. Video conferencing can only be initiated by the TMD Counselor.
4. Telehealth Services may not be as complete as in-person services. If the TMD Counselor believes the client would be better served by in-person services, the client will be referred to a local mental health professional.

5. Clients are expected to do their best to ensure they are in a safe and private environment for Telehealth sessions, i.e. being in a space with minimal distractions and not driving during sessions.
6. Emergencies and crises are inappropriate for Telehealth Services sessions. Please contact 988, 911, or visit the nearest Emergency Room if a crisis arises.
7. Instant access to a counselor is not available by email or text services. Services and communications are only available during normal business hours, unless other arrangements are specifically made with the TMD Counselor.
8. Email and text are not a forum for discussing serious issues or counseling. Texting and email should be reserved for appointment updates or minimal communication. Therefore, expect brief responses from us until your next session.
9. The TMD Counseling Line doesn't accept text nor caller ID - leave a voicemail with your name ***and*** phone number.

Electronic Communication:
Regarding the consent for electronic communications, please select ***one*** of the following options:
☑ I consent to all electronic communication (email, text, voicemail)
☑ I agree to confidential information including that which falls under HIPAA to be left in messages. However, exceptions to my consent for electronic communication are as follows: _____
☐ I do not consent to electronic communication.

NOTICE TO CLIENTS

Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology.

Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint.

Please call 1-800-821-3205 for more information.

Texas Behavioral Health Executive Council
George H.W. Bush State Office Building 1801 Congress Ave., Ste. 7.300 Austin, Texas 78701
https://www.bhec.texas.gov/discipline-and-complaints/index.html Main Line (512) 305-7700

If you believe that your rights have been violated, please contact the Texas Military Department Counseling Program Manager, the Texas Behavioral Health Executive Council or the Office of Civil Rights. Your services will not be affected in any way if you file a complaint.

To file a complaint with the Office of Civil Rights, call or write: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. SW, Washington, DC 20201 or toll-free phone 1-877- 696-6775.

I, the client, have read, understand, and consent to the above terms for counseling and agree to initiate clinical treatment with the Texas Military Department Counseling Program. My signature below also indicates that I have read the notice of privacy policies included in this consent form and that I have been provided an opportunity to ask questions about the program's privacy practices as they pertain to my protected health information.

Print Name of Service Member & D.O.B.	Signature of Service Member,	Date Signed
Print Name of TMD Counselor, Credential(s)	Signature of TMD Counselor, Credential(s),	Date Signed

LEGAL GUARDIAN ADDENDUM

*This page ***must*** be completed by the Service Member's legal guardian in order to commence treatment with a Service Member who is a non-emancipated minor

I verify that I am the legal guardian and have the right to consent for service of my minor child. I have provided the necessary legal documentation substantiating my rights to consent to services for my child (if applicable). If my legal guardianship status changes, I agree to inform and provide any applicable legal documentation to the treating provider.

I have read, understand, and consent to the above terms for counseling and agree for my minor child to initiate clinical treatment with the Texas Military Department Counseling Program. I understand that treatment with the Texas Military Department Counseling Program is voluntary. Therefore, if at any point my child no longer wants to participate in counseling services with our program, we will honor their decision to end services and notify you of their decision.

My signature below also indicates that I have read the notice of privacy policies included in this consent form and that I have been provided an opportunity to ask questions about the program's privacy practices as they pertain to my child's protected health information.

Parent/Legal Guardian Marital Status:

☐ Single, never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Parent/Legal Guardian Printed Name

Contact Information

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Marital Status:

☐ Single, never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Parent/Legal Guardian Printed Name

Contact Information

Parent/Legal Guardian Signature

Date

Texas Military Department Counseling Program

CLIENT SELF-REPORT BIOPSYCHOSOCIAL

Prior to completing this form, please review the Informed Consent for Treatment

Demographic Information

Name: _____ Email: _____

Home#: _____ Mobile#: _____ Work#: _____

Address: _____

Street Address City County State Zipcode

Sex (In Deers): ☐ Female ☐ Male DOB:

What is your preferred method of contact? ☐ Email ☐ Phone

May we leave voicemails? ☐ Yes ☐ No If yes: ☐ Home ☐ Work ☐ Mobile

Rank: _____ Component: ☐ TXARNG ☐ TXANG ☐ TXSG ☐ Family Member

Brigade/Wing: _____ Years of Service: _____ Duty Status: ☐ M-Day ☐ AGR ☐ ADOS

If on current State Active Duty orders, please list mission: _____

Do you believe your current issues are military service related? ☐ Yes ☐ No

Commanding Officer Name & Contact #: _____

Ethnicity: ☐ Black/African American ☐ White/Caucasian ☐ Hispanic/Latino ☐ Other

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status (in DEERS): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Name: _____

Emergency Contact #: _____ Emergency Contact Address: _____

Employment: ☐ Full-Time ☐ Part-Time ☐ Looking for Employment ☐ Not Employed

Employer: _____

Insurance: ☐ Yes ☐ No If yes, insurance company: _____

Mental Health Benefits? ☐ Yes ☐ No

How were you referred to our program? ☐ BH ☐ Chaplain ☐ Commanding Officer

☐ Community Resource ☐ FSS ☐ J9 ☐ SAPR ☐ Self ☐ Other

What is your reason for seeking counseling and what are you hoping to achieve?

Client Information and History

What information about your upbringing do you find relevant and important for us to know (please include any family, socioeconomic, academic, geographical, cultural, and spiritual, or other factors):

Highest Level of Education: ☐ Associates ☐ Bachelors ☐ Masters ☐ High School/GED
☐ Some College ☐ Trade/Technical School ☐ Other

Current Employment or Academic Stressors? ☐ Yes ☐ No

Financial Status: ☐ Stable ☐ Financial Stress

Areas of Financial Need (housing, utilities, childcare, transport, credit repay, etc.):

Current Living Situation: ☐ live alone ☐ live with family/friend(s)/roommate(s)
☐ homeless ☐ military housing ☐ inconsistent housing ☐ other

Name of current spouse/partner:

Length of time with current spouse/partner:

Any previous or current relationship information (stressors, strengths, marital status changes, or other historical context) that you feel is relevant to treatment:

Do you have any children? If yes, provide name(s), age(s), and specify if they reside with you:

Describe your current support system (types or names of supports, if applicable):

Military history (please include any active duty, MOS, deployment, and activation history you feel is relevant for us to know):

Current benefits and/or stressors related to military service?

Current military resources utilized: ☐ VA ☐ Peer Support Group ☐ LOD in place/pending

☐ Vet Center ☐ TX Substance Abuse Counselor ☐ MEB Pending ☐ Other:

Current or history of military-related disciplinary action(s)? ☐ Yes ☐ No

If yes, provide details (issues, date, disposition):

Current/pending or history of legal involvement or charges? ☐ Yes ☐ No

Current Psychiatric Treatment? ☐ Yes ☐ No

If yes, please provide details (diagnosis, psychotropic medications currently prescribed/taking):

History of outpatient mental health treatment? ☐ Yes ☐ No

If yes, please provide details (timeframes, diagnosis, treatment, was it helpful or not, etc.):

History of inpatient behavioral health hospitalization? ☐ Yes ☐ No

If yes, please provide details (timeframes, diagnosis, treatment, was it helpful or not, etc.):

Family history of mental health related concerns or conditions?

How would you describe your physical health?

Current medical conditions/issues (include any diagnosis and whether treated/managed well):

Current medications and/or supplements prescribed/taking:

History of brain injury, including TBI? ☐ Yes ☐ No

If yes, provide details:

Current alcohol and/or substance use? ☐ Yes ☐ No

History of alcohol and/or substance use? ☐ Yes ☐ No

If yes, provide details:

Family history of alcohol and/or substance misuse? ☐ Yes ☐ No

If yes, provide details:

Any other information that you feel is relevant for your counselor to know at this time:

General Anxiety Disorder (GAD-7)

NAME: DATE:

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column	0	0	0	0
TOTAL SCORE *(add your column scores)*	0			
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, 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?	☐	☐	☐	☐

Scoring *Add the results for question number one through seven to get a total score.*
If you score 10 or above you might want to consider one or more of the following:
1. Discuss your symptoms with your doctor,
2. Contact a local mental health care provider or
3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

A score of 10 or higher means significant anxiety is present. Score over 15 are severe.

GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

Reset Form

Name: Date:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 ☐

FOR OFFICE CODING 0 + 0 + 0 + 0

=Total Score: 0

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**
☐	☐	☐	☐

Reset Form

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

SHORT FORM PCL-5

Date:_____

Name _____

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping the worst event in mind, read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past WEEK.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0 ○	1 ○	2 ○	3 ○	4 ○
2. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0 ○	1 ○	2 ○	3 ○	4 ○
3. Feeling distant or cut off from other people?	0 ○	1 ○	2 ○	3 ○	4 ○
4. Irritable behavior, angry outbursts, or acting aggressively?	0 ○	1 ○	2 ○	3 ○	4 ○
COLUMN SUM					

TOTAL 0

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD
Zuromski et al (2019). Developing an optimal short-form of the PTSD Checklist for DSM-5 (PCL-5). Depress Anxiety, 36, 790-800.

Threshold 6+

Clear Form

Name: **Date:**

Perceived Stress Scale (PSS-10)

Instructions:

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way.

In the last month, how often have you...

		Never	Almost Never	Sometimes	Fairly Often	Very Often
1	been upset because of something that happened unexpectedly?	0	1	2	3	4
2	felt that you were unable to control the important things in your life?	0	1	2	3	4
3	felt nervous and "stressed"?	0	1	2	3	4
4	felt confident about your ability to handle your personal problems?	4	3	2	1	0
5	felt that things were going your way?	4	3	2	1	0
6	found that you could not cope with all the things that you had to do?	0	1	2	3	4
7	been able to control irritations in your life?	4	3	2	1	0
8	felt that you were on top of things?	4	3	2	1	0
9	been angered because of things that were outside of your control?	0	1	2	3	4
10	felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

TOTAL: 0

Developer Reference:

Cohen, S., & Williamson, G. (1988). Perceived stress in a probability sample of the United States. In S. Spacapan & S. Oskamp (Eds.), The social psychology of health: Claremont Symposium on applied social psychology. Newbury Park, CA: Sage.

Clear Form