INFORMED CONSENT NOTICE, PRIVACY PRACTICES AND FEE AND PAYMENT AGREEMENT

Before we begin psychological services together, there are some things that you ought to know about the therapy process and about my office. This is called "Informed Consent". This information contained here will help you understand better what to expect and will explain privacy practices and some limitations about what we will be doing together.

A BRIEF HIPAA OVERVIEW:

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with our privacy practices for use and disclosure of PHI for treatment, payment or health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information before this session. When you sign this document, it will also represent an Agreement between us. You may revoke this Agreement in writing at any time.

CONFIDENTIALITY

All of our work together, our conversations, your records and any information that you provide, is protected by legal privilege. This means that the law protects you from having information about you given to anyone. This office respects your privacy and intends to honor your privilege. However, there are some exceptions to your privacy that you should understand.

LIMITS ON CONFIDENTIALITY

We may use or disclose your protected health information (PHI) for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"

- Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another clinician or psychologist.

- Payment is when we help you obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to assist you in obtaining reimbursement for your health care or to determine eligibility or coverage.

- Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations (of PHI) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. Since this office is out of network with all insurance plans, typically this does not apply.

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners of Social Workers, they have the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

CLIENT RIGHTS:

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are 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 and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, we will send your superbills 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. We may deny access to PHI under circumstances, but in some cases you may have this decision reviewed. You may examine and/or receive a copy of your Psychotherapy Notes unless we determine that release would be harmful to your physical, mental or emotional health. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend –** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting –** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, we will discuss with you the details of the accounting process.
- **Right to a Paper Copy –** You have the right to obtain a paper copy of the notice from us upon request.

CLINICIAN 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 are required to keep PHI for five years.
- 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 revise our policies and procedures, we will notify you in writing by mail.

- The procedures for selecting, giving, and scoring the screening tests, interpreting and storing the results, and maintaining your privacy will be carried out in accord with the rules and guidelines of HIPAA, the American Psychological Association and other professional organizations.
- Screening tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.) These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
- Screening tests and results will be kept in a locked, safe place either onsite for one year and/or at a secure offsite location for five years.
- You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents.

COMPLAINTS

If you are concerned that your rights have been violated, or you disagree with a decision we made about access to your records, you may contact the Privacy Officer for Nancy Peskin, LCSW in writing to: Privacy Officer c/o Nancy Peskin, LCSW, 2217 Park Avenue, Pearland TX 77581. You may also file a complaint to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, 1301 Young Street, Suite 1169 Dallas, TX 75202 or calling (214) 767-4056.

UNDERSTANDING OF TREATMENT SERVICES

I, _____hereby seek and consent to take part in the face to face psychological treatment and authorize Nancy Peskin, LCSW to perform an initial interview, therapy and/or brief psychological screeners on me.

Services may also include the clinician's time required for the reading of prior records, consultations with other providers and professionals, scoring, interpreting results, report writing and any other activities to support these services. I agree to help as much as I can by supplying full answers, making an honest effort and working as best as I can to make sure that the findings are accurate.

Additionally, I am aware that the practice of psychotherapy or counseling is not an exact science and that the predictions of the effects are not precise nor guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures by this treating therapist. Further, I understand that evaluation and treatment will involve discussion of personal events in my and/or my families own history which, at times, can be discomforting and is at times very personal. I am aware that I may terminate my treatment at any time without consequence, but that I will remain responsible for payment for services that I have received.

MISSED APPOINTMENT POLICY

The policy concerning missed appointments has been explained to me. I understand that if I miss a confirmed appointment and do not call to reschedule within 14 days, this office will accept this as your notice that you have terminated this agreement and that you wish to discontinue services with our office. I understand that I may be charged for my missed appointment equal to the fee of the appointment. I also understand after two late cancelled or missed appointments, I may be referred out to another clinic.

EMAIL CORRESPONDENCE

Professional, clinical advice will not normally be provided electronically. Administrative staff will not utilize email. Should you initiate email contact via my website:

● Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

● No one can diagnose or treat your condition from email or other written communications, and communication via website or email cannot replace the relationship you have with a healthcare practitioner.

● Emails are checked during business hours only. If you have a crisis matter that requires urgent immediate attention after hours, please call 911 or visit a local emergency room.

● Communications via email or other non-portal text are not encrypted, but are still considered part of your health record.

● Any text or email initiated by yourself is an implicit consent to receive electronic communications from our office and provider within the same medium (i.e. sending an email to Nancy Peskin, LCSW's gmail account implies agreement to receive a reply via gmail).

Do you consent to electronic/email communication? (i.e. via gmail or other non-encrypted accounts)
Y or N

Would you like to receive email appointment reminders as a courtesy? **Y or N**
(please be advised that these emails may go into your spam/junk folder)

Email:_____
Please provide your email address only if you consent to email correspondence.
(**please print neatly**)

I have read, understood, and agree to the above guidelines on electronic communications.

Signature: _____ Date: _____

FEES AND PAYMENTS

The client assumes 100% responsibility for all services, including any and all balances from pre-approved out of network insurance coverage. Unless other arrangements have been made, I understand that the fee for this (these) service(s) will be $225 for the 90 minute initial clinical interview and $175 per 50 minute session for subsequent therapy appointments. Payment in full is due at the time of services.

The rate of **out of network** insurance reimbursement varies according to individual insurance contracts and I understand that I may be reimbursed based on my own health plan benefits and that I can request a "superbill" (a more detailed statement) from this office so that I may submit bills to my insurance company for any benefits. Though my health insurance may repay me for some of these fees, I understand that I am fully responsible for full payment for these services. I also understand that once services have been provided, (initial interview, testing, therapy, and other requested services) no refunds (credit card or checks) will be issued. Additionally, I am aware that missed appointments may be subject to a charge equal to the fee of the therapy appointment.

Occasionally, clients receiving services will request that the clinician respond to frequent emails/calls, review letters/records, write letters, call attorneys and other professionals. If these requests become time consuming, we will collect payment of $175/hr pro-rated or an administrative retainer of $500.

Additionally, if we are asked to make copies of sizable quantity of records, there may be a fee of $1 per page (up to $20) and .50 cents per page after. Additional hourly fees ($175/hr) may apply for record review prior to copying records. Shipping charges, if applicable, will be included in the fee. We ask that you provide us with copies of pertinent records, not the originals.

Acknowledgement and Consenting signatures will be obtained during our initial consultation together.

I look forward to meeting you!

_____Original to client's chart _____ Copy of HIPAA document to client

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Upon complete review of all documents in this packet, pages 1-15, your therapist will provide an Acknowledgement and Consent form to be signed by you (the client) and your therapist during the initial sessions.

I (the client) understand that pages 1-15 (Excluding Signature Page, page 6) of this packet are available to me anytime online at www.pearlandcounselingcenter.com or by request. This request can be made in person at Pearland Counseling Center, 2217 North Park Avenue, Pearland, Texas 77581.

I (the client) understand that my signature is required on the Acknowledgement and Consent form before services can be provided. I (the client) understand that **if I choose NOT to sign the Acknowledgement and Consent form counseling services will not be provided.**

IMPORTANT: It is required the Acknowledgement and consent for is signed by you (the client) and witnessed prior to the start of counseling services.

CLIENT REGISTRATION PAGE

TODAY'S DATE: _____

Patient Name: _____ DOB: __ __ - __ __ - __ __ __ __ Age: ___ Gender: ___

Marital Status: **SINGLE MARRIED DIVORCED WIDOWED** SS#: __ __ __ - __ __ - __ __ __ __ DL#: __ __ __ __ __ __ __ __

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

May we contact your home #? _____ May we contact your work #? _____ May we contact your cell #? _____

May we leave a message? Y N May we leave a message? Y N May we leave a message? Y N

E-Mail Address: _____

Employer: _____ Occupation: _____

Emergency Contact

Name: _____ Relationship: _____

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

Name of person responsible for this client: _____ Relationship: _____

MEDICAL HISTORY

Reason for seeking Counseling: _____

_____

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: _____ Phone #: __ __ __ - __ __ __ - __ __ __ __

Current physical problems (describe): _____

_____

Current Medications: _____

_____

POLICY FOR NO SHOW/LATE CANCEL AND OUTSTANDING BALANCE DUE

We are very committed to serving our clients and strive to accommodate all of our clients by making appointments available as soon as possible.

When an appointment is reserved for you, we require that the appointment be cancelled by **1:00 pm the day prior to the appointment.** We understand that emergencies happen, and we will be happy to work with you in those situations. If you have any questions, please feel free to speak with our office manager.

****

I understand that I will be responsible for a **missed appointment fee equal to the same amount of an attended appointment** and that my credit card will be charged if I am unable to provide the proper notice that I will not keep my scheduled appointment. Note: This policy may also apply to sessions provided by Employee Assistance Programs (EAP).

I also understand that I will be responsible for any outstanding balance for services rendered and that my credit card will be charged to pay for the outstanding balance.

If you choose to provide your flexible spending account information, an additional credit or debit card number is required as the situation may occur that your flex account holds insufficient funds or its balance has become depleted.

We accept the following debit/credit cards: Visa, Discover, American Express and MasterCard.

FOR FLEX CARD:

Name As Appears On Card: _____

Credit Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: _____

FOR CREDIT/DEBIT CARD:

Name As Appears On Card: _____

Credit Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: _____

I have read, understand and agree to the Policy above and give my permission for my card to be charged if a violation occurs.

Print Name: _____

Signature: _____ Date: _____

I _____ (CREDIT CARD HOLDER NAME) understand that by providing my Credit Card information I am consenting to being financially responsible for _____ (CLIENT NAME) regarding any violation of the Policy stated above.

Print Name: _____

Signature: _____ Date: _____

You may revoke this consent at any point, by submitting a request in writing which MUST include:
Date of request, client's name, your name, signature, copy of your current Driver's License, and an explanation of the information to be removed. If you are mailing your request, please keep in mind there could be charges to your card until your request is received by our office.

OFFICE USE ONLY: DATE OF REVOKE REQUEST: _____ DATE REQUEST REC'D (EFF. DATE OF REVOKE): _____

Nancy L. Peskin, LCSW

The River Oaks Tower
3730 Kirby Drive
Houston, TX 77098

Pearland Counseling Center
2217 Park Ave
Pearland, TX 77581

npeskinlcsw@gmail.com

ADULT QUESTIONNAIRE

I. Personal Information

Name_____ D.O.B_____ Gender_____ Age_____

Address:_____ City:_____State/Zip code:_____

Cell Phone:_____ Home Phone:_____ Email:_____

Marital Status:_____ Ever divorced? ___Yes ___No If yes, was decision mutual?_____

Do you have children? ___Yes ____No If yes, how many?_____

Emergency Contact/phone and relation to you:_____

Were you referred and if yes, by whom?_____

II. Current Concerns:

1. What are you most concerned about that has led you to see me today?_____

_____

2. What symptoms are you now experiencing that are causing you concern? How severe are they and approximately when did they begin?_____

_____

3. Are there any medical conditions of which you are aware that could explain these symptoms? ____**Yes** ____ **No**
If yes, please explain:

_____

_____

4. Have any situations, good or bad, occurred at home, work, school or socially that could be an unwanted source of stress for you? If so, please explain:

_____

_____

_____

5. Please circle any of the follow words below that apply to you:

Worthless, useless, a 'nobody", "life is empty", inadequate, stupid, incompetent, "can't do anything right"

Guilty, evil, morally wrong, horrible thoughts, hostile, full of hate

Anxious, agitated, cowardly, naive, unassertive, panicky, aggressive

Ugly, deformed, unattractive, repulsive, shameful, inferior, disgusting

Depressed, lonely, unloved, misunderstood, bored, restless

Confused, unconfident, in conflict, full of regrets, in despair, suicidal

Worthwhile, sympathetic, intelligent, attractive, confident, considerate, hopeful

6. What personal strengths do you have that help you cope?_____

_____

III. Childhood and Adolescent Historical Information

Please describe any significant childhood diseases/illnesses/surgeries/injuries:_____

_____

Indicate if you experienced any of the following difficulties growing up (Please circle your "YES" responses)

Hyperactivity	Low Self-Esteem
Problems with Attention	Sexual Identity (gay/lesbian/bi-sexual)
Problems with Self-Control	Overly Passive
Problems with Learning in School	Nervous
Aggressive Behavior	Worried
Started Fights	Disorganized
Bullied Others	Forgetful
Lying	Trouble Learning in School
Stealing	Unmotivated in School
Unhappy	Trouble with Reading or Writing
Few friends	Trouble with Math
Gender Identity	Was bullied

What was a favorite childhood hobby, craft or activity you enjoyed that passed the time without you even noticing?

_____

IV. Role of religion and/or spirituality in your life:

A. In childhood:_____

B: As an adult:_____

V. Health Information

Have you had or do you have currently any of the following conditions? (Please circle your "YES" responses)

Headaches	Head Injury
Dizziness	Memory problems
Fainting	Insomnia
Tremors	Inattention
Stomach troubles	Concentration difficulties
Bowel disturbances	Home conditions bad
Anger	Conflict at home or work
Ongoing Nightmares	Unable to relax
Hyperactivity	No appetite
Allergies	Overeating
Asthma	Purging intentionally
Cardiac Problems	Surgery complications
High Blood Pressure	Diabetes
Seizure Disorder	Sexual problems
Broken Bones	Problems with fertility
Alcoholism	Hearing Problems
Excessive sweating	Vision Problems
Cancer	Psychiatric Problems
Bingeing	Previous psychiatric hospitalizations

Further details/dates on any of the above you circled:_____

_____

Are you currently taking any medications? Please list, if yes:_____
_____

List any other significant health difficulties you have now or have had in the past_____
_____

Who is your current primary care physician?_____If female, Ob/Gyn:_____

Are you being treated by any other health professionals? If yes, provide name/s:_____

_____

VI. Educational Information

The highest grade completed:
___high school ___some college___graduated college ___college +

Describe any problems you may have had in school:_____

_____

VII. Social History

Which of the following best describes you most of the time (Check all that apply)

___generally feel positive	___mood changes from happy to sad easily
___generally feel optimistic	___quick to anger
___confident in my abilities	___irritable
___cheerful and generally happy	___sad/depressed much of the time
___slow to anger	___afraid to take chances
___anxious, generally worried	___trouble making decisions
___obsessive thoughts	___feelings of dread

Do you have trouble making friends? ___yes ___no If yes, please provide details:_____

_____

Do you have trouble keeping friends? ___yes ___no If yes, please provide details:_____

_____

Do you have trouble controlling your anger? ___yes ___no If yes, please provide details:_____

_____

Do you drink alcohol? ___yes ___no If yes, how often? _____

Has anyone close to you commented or complained about your drinking? ____yes ____no If yes, please explain:

_____

Have you ever attended a 12-step support group for any issues like drugs, alcohol, sex, food? ____yes ____no

If yes, what type of group and was it helpful? _____

VIII. Employment History

Are you currently employed? _____yes _____no

Current Employer:_____
Current Occupation:_____

Are you satisfied with your job?: _____yes _____no If not, why not:_____
Length of time in your current job:_____

IX. Please complete the following 20 questions only if you are being seen today for food and body issues:

*Answer **YES or NO** to the following questions based on your habits and attitudes CURRENTLY. Make side notes about any of the questions that affected you in the PAST. *EDIT™ Assessment*

1.	I use diet pills, metabolism-boosting pills, or other weight-loss aids.	Yes	No
2.	I have been on and off more diets than I can count.	Yes	No
3.	I am very aware of my intake of fat, carbohydrate and/or calories.	Yes	No
4.	I have recently lost and/or gained more than 30 pounds.	Yes	No
5.	My mood improves when I feel in control of my weight/eating.	Yes	No
6.	I feel guilty if I eat too much or if I eat foods I think I shouldn't.	Yes	No
7.	There are certain foods I try to never eat (i.e., fried foods, desserts).	Yes	No
8.	I hide food or lie to others about how much I actually eat.	Yes	No
9.	I sometimes feel unable to stop eating once I start.	Yes	No
10.	There are things I hate about the shape and/or size of my body	Yes	No
11.	I use food as a comfort or an escape from my problems.	Yes	No
12.	I often skip meals and sometimes go an entire day without eating.	Yes	No
13.	My eating and/or exercise patterns are making me somewhat isolated.	Yes	No
14.	I have a difficult time identifying or handling my feelings.	Yes	No
15.	I spend a great deal of time planning meals and thinking about food.	Yes	No
16.	I avoid social situations because I'm ashamed of my eating / weight.	Yes	No
17.	I worry about gaining weight or becoming fat.	Yes	No
18.	I just don't feel right unless I exercise every day.	Yes	No
19.	I sometimes vomit after meals or use laxatives to control my weight.	Yes	No
20.	Once I reach my goal weight, then I'll feel good about myself.	Yes	No

X. Anxiety Checklist

Check **YES** or **NO** to any question that best describes your mood/behaviors over the past **2 weeks**:	Yes	No
I become intensely fearful in certain situations and experience several of the following symptoms: **(If yes, please circle your specific "YES" responses below)** • palpitations or accelerated heart rate • sweating • trembling or shaking • sensations of shortness of breath or smothering • feeling of choking • chest pain or discomfort • nausea or abdominal distress • feeling dizzy or lightheaded or faint • feelings of unreality or of being detached from oneself • fear of losing control • fear of dying • numbness • chills or hot flashes	_____	_____
I become anxious about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available		
I have a persistent fear that is excessive or unreasonable that is triggered by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection)		
I have a persistent fear of being embarrassed in social situations		
Social situations almost always cause me to become anxious		
I try to avoid situations that cause me to be afraid		
I have recurrent thoughts or impulses that are inappropriate and cause me to become anxious or distressed.		
I perform repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., Praying, counting, repeating words silently) to prevent something negative from occurring		
I have experienced, witnessed, or was exposed to an event or events that involved actual or threatened death or serious injury or a threat of such and I have recurrent distressing recollections of the event that interfere with my thinking.		
I have experienced excessive anxiety and worry on more days than not for at least the past six months.		

XI. Mood Problems Checklist

Please check the box that best describes your mood and behavior over the past two weeks and also mark if this has been present for 2 years or more.

	Present Yes	No	2+ yrs
I feel depressed most of the day, nearly every day	__	__	_____
I have little interest in doing things or find little pleasure in the things I used to enjoy			
I have had a significant weight loss/gain (more than 5% in a month) or change in appetite			
I have trouble falling asleep or I sleep too much nearly every day			
I have trouble concentrating and making decisions daily			
I have recurrent thoughts of death, recurrent suicidal thoughts			
I feel worthless or guilty nearly everyday			
Lately, my self-esteem is very good and I feel as if I could do just about anything			
I have less need for sleep than I usually do			
I am more talkative than usual or feel pressure to keep talking			
My ideas change often and my thoughts are racing			
I have become very distractible			
I am more focused in accomplishing goals than I normally am			
I have become involved in pleasurable activities that have had negative consequences (e.g., unrestrained buying sprees, sexual indiscretions, or foolish business investments)			

My goodness! That was a lot of questions, right? We're almost done. I realize that I've have focused largely on problems that you may be having. However, I am also quite interested in understanding your strengths, talents, skills and accomplishments. Please share with me some of your achievements and proud moments!

_____

_____

Thank you! I'm looking forward to talking with you.