DR. MICHAEL MCGOWAN
PSY.D., MA, MBA
SPECIALIZING IN CBT AND EMDR
WEB AND PHONE THERAPY AVAILABLE

Contract Agreement

As a patient at Scottsdale Psychological Services, we requires that you agree to the following terms of our practice: (**please initial and sign below**)

_____Co-pays and co-insurance fees are payable at the time of your appointment.

_____We require that you have a credit card on file; as fees are charged for all accounts each evening. **Note: a credit card must be on file before an appointment can be scheduled.**

_____If you cannot get an appointment when you want, ask to be put on our waiting list. When cancellations occur, we call people on our wait list first.

_____When you make an appointment with Dr. McGowan, we are reserving one hour for you.

_____If you need to reschedule or cancel an appointment you must call us by 10:00 AM of the prior business day to avoid a $110 late cancellation fee.

_____If we are able to fill your appointment cancellation with another patient on our waiting list after 10:00 AM of the prior business day; you will only be charged $75.00.

_____All sessions are the standard therapy hour of 53 minutes.

_____we only see individual clients age 21 and older.

_____We no longer do family or couples therapy, the person who wants to be seen must call our office and make his/her own appointment.

_____Unpaid co-payments are usually charged to your card within 2 days of your appointment.

_____ **You** are responsible for any reimbursements denied for any reason by your insurance company.

_

_____Psychological testing CPT Code is 96130 may not covered by your insurance company (cost varies by test). Check with your insurance company about your coverage before scheduling testing.

_____Consultation with individuals who are not patients ($175.00 per hour).

_____ HIPPA and Arizona state laws govern how 3rd party requests for patient records are handled.

_____Reports or completion of forms or third-party consultations that you request are charged $200.00 per hour.

_____Subpoenas for psychotherapy notes or records will only be honored if ordered by a judge. Any court ordered appearance regarding your case will be billed at $350.00 per hour. Travel time and waiting time are charged at this rate, plus all travel expenses.

_____If you request a letter or report, you will be charged $250.00 per hour spent writing the report. Any research that is required for your report is billed at this rate.

_____Telephone calls between Dr. McGowan, patients, other treatment facilities, or care providers are billed at $50.00 per 15-minute time frame. Minimum charge is $75.00

Signature: _____ Date: _____

_____

Print name

New Policy Which Replaces Prior Agreements and Therapy Contract

Bank/Credit Card Authorization Form

Bank/Credit Card Co. Name:	
MC/ VISA/ DISC	Expiration Date:
Credit Card Number:	
CVS:	
Card Owner Name:	
Card Billing Address and Zip Code:	

Please note: All cards are verified by our billing staff prior to your appointment.

This form authorizes Scottsdale Psychological Services (Merchant) to debit the above account for fees related to "no show" and cancelled appointments not cancelled by **10 AM of the prior business** day to your appointment and for copays not paid at the time of the appointment. Unfortunately we are unable to call you before a charge is applied to your credit card.

Appointment cancellations or rescheduling must be made with the appointment with Harpreet between 9am to 5pm Monday to Friday.

Cancellation or "no show" fees are $110.00

Dated this_____ ___day of_____, 20_____

Card Owner Signature:
Card Owner Printed Name:

This policy is necessary so that we can give a cancelled appointment in an emergency situation or to a patient on our waiting list. Insurance require us to give new patients appointments as soon as possible. We appreciate you cooperation and look forward to working with you.

Thanks,

Dr. Michael McGowan

Clinical Psychologist

Medical and Psychiatric History

Please report your history of physical or mental illness, as well as any current diagnoses

Diagnosis/Disease Please specify diagnosis and age of onset.	**Current/Past Treatment** Please identify interventions or medications here.	**Were these interventions/medications helpful?** Yes/No	**Were you ever hospitalized or have any surgeries for this?** If so, please specify	**Is this current?** If not, when was the last time you experienced symptoms?

● www.doctormcgowan.com ● 8426eshea@gmail.com ●
● Phone: (480) 225-3236 ● Fax: (623)999-9272 ●

PATIENT INTAKE FORM

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____ Occupation _____

Home Phone _____ Work/Mobile phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Ins. ID No. _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birth date _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Ins. ID No. _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

I give permission for treatment of myself/my dependent to my assigned provider.

_____ _____ _____
Responsible Party Signature Relationship Date

Payment Options

We are offering new payment options:

Cash payment for services: No Discount

Check: No Discount

Credit Card: $2.50 charge processing fee

Please sign and print your name acknowledging that you have received and agree to the revised payment schedule.

_____ _____ _____

Signature Date Print Name

BHS®

Date:_____

Name:_____ Marital Status:_____ Age:_____ Sex:_____

Occupation:_____ Education:_____

This questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the **past week including today**, darken the circle with a 'T' indicating TRUE in the column next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' indicating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

1.	I look forward to the future with hope and enthusiasm.	(T) (F)
2.	I might as well give up because there is nothing I can do about making things better for myself.	(T) (F)
3.	When things are going badly, I am helped by knowing that they cannot stay that way forever.	(T) (F)
4.	I can't imagine what my life would be like in ten years.	(T) (F)
5.	I have enough time to accomplish the things I want to do.	(T) (F)
6.	In the future, I expect to succeed in what concerns me most.	(T) (F)
7.	My future seems dark to me.	(T) (F)
8.	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	(T) (F)
9.	I just can't get the breaks, and there's no reason I will in the future.	(T) (F)
10.	My past experiences have prepared me well for the future.	(T) (F)
11.	All I can see ahead of me is unpleasantness rather than pleasantness.	(T) (F)
12.	I don't expect to get what I really want.	(T) (F)
13.	When I look ahead to the future, I expect that I will be happier than I am now.	(T) (F)
14.	Things just won't work out the way I want them to.	(T) (F)
15.	I have great faith in the future.	(T) (F)
16.	I never get what I want, so it's foolish to want anything.	(T) (F)
17.	It's very unlikely that I will get any real satisfaction in the future.	(T) (F)
18.	The future seems vague and uncertain to me.	(T) (F)
19.	I can look forward to more good times than bad times.	(T) (F)
20.	There's no use in really trying to get anything I want because I probably won't get it.	(T) (F)

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San Diego • Philadelphia • Austin • Fort Worth • Toronto • London

015-413362-0

Name: _____ Age: _____ ID #: _____

Date: _____ Gender: ☐ Male ☐ Female Education (Years Completed): _____

Ethnicity: ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

PDSQ

TEST BOOKLET

Mark Zimmerman, M.D.

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This form asks you about emotions, moods, thoughts, and behaviors. For each question, check the box in the *Yes* column if it describes how you have been acting, feeling, or thinking. If the item does not apply to you, check the box in the *No* column. **Please answer every question.**

Yes	No		DURING THE PAST 2 WEEKS...
☐	☐	1.	...did you feel sad or depressed?
☐	☐	2.	...did you feel sad or depressed for most of the day, nearly every day?
☐	☐	3.	...did you get less joy or pleasure from almost all of the things you normally enjoy?
☐	☐	4.	...were you less interested in almost all of the activities you are usually interested in?
☐	☐	5.	...was your appetite significantly *smaller* than usual nearly every day?
☐	☐	6.	...was your appetite significantly *greater* than usual nearly every day?
☐	☐	7.	...did you sleep at least 1 to 2 hours *less* than usual nearly every day?
☐	☐	8.	...did you sleep at least 1 to 2 hours *more* than usual nearly every day?
☐	☐	9.	...did you feel very jumpy and physically restless, and have a lot of trouble sitting calmly in a chair, nearly every day?
☐	☐	10.	...did you feel tired out nearly every day?
☐	☐	11.	...did you frequently feel guilty about things you have done?
☐	☐	12.	...did you put yourself down and have negative thoughts about yourself nearly every day?
☐	☐	13.	...did you feel like a failure nearly every day?
☐	☐	14.	...did you have problems concentrating nearly every day?
☐	☐	15.	...was decision making more difficult than normal nearly every day?
☐	☐	16.	...did you frequently think of dying in passive ways like going to sleep and not waking up?
☐	☐	17.	...did you wish you were dead?
☐	☐	18.	...did you think you'd be better off dead?
☐	☐	19.	...did you have thoughts of suicide, even though you would not really do it?
☐	☐	20.	...did you seriously consider taking your life?
☐	☐	21.	...did you think about a specific way to take your life?

☐	☐	22.	Have you *ever experienced* a traumatic event such as combat, rape, assault, sexual abuse, or any other extremely upsetting event?
☐	☐	23.	Have you *ever witnessed* a traumatic event such as rape, assault, someone dying in an accident, or any other extremely upsetting incident?
			DURING THE PAST 2 WEEKS...
☐	☐	24.	...did thoughts about a traumatic event frequently pop into your mind?
☐	☐	25.	...did you frequently get upset because you were thinking about a traumatic event?
☐	☐	26.	...were you frequently bothered by memories or dreams of a traumatic event?
☐	☐	27.	...did reminders of a traumatic event cause you to feel intense distress?
☐	☐	28.	...did you try to block out thoughts or feelings related to a traumatic event?
☐	☐	29.	...did you try to avoid activities, places, or people that reminded you of a traumatic event?
☐	☐	30.	...did you have flashbacks, where it felt like you were reliving a traumatic event?
☐	☐	31.	...did reminders of a traumatic event make you shake, break out into a sweat, or have a racing heart?
☐	☐	32.	...did you feel distant and cutoff from other people because of having experienced a traumatic event?
☐	☐	33.	...did you feel emotionally numb because of having experienced a traumatic event?
☐	☐	34.	...did you give up on goals for the future because of having experienced a traumatic event?
☐	☐	35.	...did you keep your guard up because of having experienced a traumatic event?
☐	☐	36.	...were you jumpy and easily startled because of having experienced a traumatic event?

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Yes	No		DURING THE PAST 2 WEEKS...
Y	N	37.	...did you often go on eating binges (eating a *very large* amount of food very quickly over a short period of time)?
Y	N	38.	...did you often feel you could not control how much you were eating during an eating binge?
Y	N	39.	...did you go on eating binges during which you ate so much that you felt uncomfortably full?
Y	N	40.	...did you go on eating binges during which you ate a large amount of food even when you didn't feel hungry?
Y	N	41.	...did you eat alone during an eating binge because you were embarrassed by how much you were eating?
Y	N	42.	...did you go on eating binges and then feel disgusted with yourself afterward?
Y	N	43.	...were you very upset with yourself because you were going on eating binges?
Y	N	44.	...to prevent gaining weight from an eating binge did you go on strict diets or exercise excessively?
Y	N	45.	...to prevent weight gain from an eating binge did you force yourself to vomit or use laxatives or water pills?
Y	N	46.	...was your weight, or the shape of your body, one of the most important things that affected your opinion of yourself?

			DURING THE PAST 2 WEEKS...
Y	N	47.	...did you worry obsessively about dirt, germs, or chemicals?
Y	N	48.	...did you worry obsessively that something bad would happen because you forgot to do something important—like locking the door, turning off the stove, or pulling out the electrical cords of appliances?
Y	N	49.	...were there things you felt compelled to do over and over (for at least ½ hour per day) that you could not stop doing when you tried?
Y	N	50.	...were there things you felt compelled to do over and over even though they interfered with getting other things done?
Y	N	51.	...did you wash and clean yourself or things around you obsessively and excessively?
Y	N	52.	...did you obsessively and excessively check things or repeat actions over and over again?
Y	N	53.	...did you count things obsessively and excessively?

			DURING THE PAST 2 WEEKS...
Y	N	54.	...did you get very scared because your heart was beating fast?
Y	N	55.	...did you get very scared because you were short of breath?
Y	N	56.	...did you get very scared because you were feeling shaky or faint?
Y	N	57.	...did you get sudden attacks of intense anxiety or fear that came on from out of the blue, for no reason at all?
Y	N	58.	...did you get sudden attacks of very intense anxiety or fear during which you thought something terrible might happen, such as your dying, going crazy, or losing control?
Y	N	59.	...did you have sudden, unexpected attacks of anxiety during which you had three or more of the following symptoms: heart racing or pounding, sweating, shakiness, shortness of breath, nausea, dizziness, or feeling faint?
Y	N	60.	...did you worry a lot about having unexpected anxiety attacks?
Y	N	61.	...did you have anxiety attacks that caused you to avoid certain situations or to change your behavior or normal routine?

			DURING THE PAST 2 WEEKS...
Y	N	62.	...did things happen that you knew were true, but that other people told you were your imagination?
Y	N	63.	...were you convinced that other people were watching you, talking about you, or spying on you?
Y	N	64.	...did you think that you were in danger because someone was plotting to hurt you?
Y	N	65.	...did you think that you had special powers other people didn't have?
Y	N	66.	...did you think that some outside force or power was controlling your body or mind?
Y	N	67.	...did you hear voices that other people didn't hear, or see things that other people didn't see?

NOTE: MOST OF THE FOLLOWING QUESTIONS REFER TO THE PAST 6 MONTHS.

Yes	No		DURING THE PAST 6 MONTHS...
Y	N	68.	...did you regularly avoid any situations because you were afraid they'd cause you to have an anxiety attack?
		69.	...did any of the following make you feel fearful, anxious, or nervous because you were afraid you'd have an anxiety attack in the situation?
Y	N	a.	going outside far away from home
Y	N	b.	being in crowded places
Y	N	c.	standing in long lines
Y	N	d.	being on a bridge or in a tunnel
Y	N	e.	traveling in a bus, train, or plane
Y	N	f.	driving or riding in a car
Y	N	g.	being home alone
Y	N	h.	being in wide-open spaces (like a park)
Y	N	70.	...did you almost always get very anxious as soon as you were in any of the above situations?
Y	N	71.	...did you avoid any of the above situations because they made you feel anxious or fearful?

			DURING THE PAST 6 MONTHS...
Y	N	72.	...did you worry a lot about embarrassing yourself in front of others?
Y	N	73.	...did you worry a lot that you might do something to make people think that you were stupid or foolish?
Y	N	74.	...did you feel very nervous in situations where people might pay attention to you?
Y	N	75.	...were you extremely nervous in social situations?
Y	N	76.	...did you regularly avoid any situations because you were afraid you'd do or say something to embarrass yourself?
		77.	...did you worry a lot about doing or saying something to embarrass yourself in any of the following situations?
Y	N	a.	public speaking
Y	N	b.	eating in front of other people
Y	N	c.	using public restrooms
Y	N	d.	writing in front of others
Y	N	e.	saying something stupid when you were with a group of people
Y	N	f.	asking a question when in a group of people
Y	N	g.	business meetings
Y	N	h.	parties or other social gatherings
Y	N	78.	...did you almost always get very anxious as soon as you were in any of the above situations?
Y	N	79.	...did you avoid any of the above situations because they made you feel anxious or fearful?

			DURING THE PAST 6 MONTHS...
Y	N	80.	...did you think that you were drinking too much?
Y	N	81.	...did anyone in your family think or say that you were drinking too much, or that you had an alcohol problem?
Y	N	82.	...did friends, a doctor, or anyone else think or say that you were drinking too much?
Y	N	83.	...did you think about cutting down or limiting your drinking?
Y	N	84.	...did you think that you had an alcohol problem?
Y	N	85.	...because of your drinking did you have problems in your marriage; at your job; with your friends or family; doing household chores; or in any other important area of your life?

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Yes	No		DURING THE PAST 6 MONTHS...
Y	N	86.	...did you think that you were using drugs too much?
Y	N	87.	...did anyone in your family think or say that you were using drugs too much, or that you had a drug problem?
Y	N	88.	...did friends, a doctor, or anyone else think or say that you were using drugs too much?
Y	N	89.	...did you think about cutting down or limiting your drug use?
Y	N	90.	...did you think you had a drug problem?
Y	N	91.	...because of your drug use did you have problems in your marriage; at your job; with your friends or family; doing household chores; or in any other important area of your life?

			DURING THE PAST 6 MONTHS...
Y	N	92.	...were you a nervous person on most days?
Y	N	93.	...did you worry a lot that bad things might happen to you or someone close to you?
Y	N	94.	...did you worry about things that other people said you shouldn't worry about?
Y	N	95.	...were you worried or anxious about a number of things in your daily life on most days?
Y	N	96.	...did you often feel restless or on edge because you were worrying?
Y	N	97.	...did you often have problems falling asleep because you were worrying about things?
Y	N	98.	...did you often feel tension in your muscles because of anxiety or stress?
Y	N	99.	...did you often have difficulty concentrating because your mind was on your worries?
Y	N	100.	...were you often snappy or irritable because you were worrying or feeling stressed out?
Y	N	101.	...was it hard for you to control or stop your worrying on most days?

			DURING THE PAST 6 MONTHS...
Y	N	102.	...have you had a lot of stomach and intestinal problems such as nausea, vomiting, excessive gas, stomach bloating, or diarrhea?
Y	N	103.	...have you been bothered by aches and pains in many different parts of your body?
Y	N	104.	Do you get sick more than most people?
Y	N	105.	Has your physical health been poor *most of your life?*
Y	N	106.	Are your doctors *usually* unable to find a physical cause for your physical symptoms?

			DURING THE PAST 6 MONTHS...
Y	N	107.	...did you often worry that you might have a serious physical illness?
Y	N	108.	...was it hard to stop worrying that you have a serious physical illness?
Y	N	109.	...did your doctor say you didn't have a serious illness but it was still hard to stop thinking about it?
Y	N	110.	...did you worry so much about having a serious illness that it interfered with your activities or it caused you problems?
Y	N	111.	...did you visit the doctor a lot because you were worried that you had a serious physical illness?

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Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score