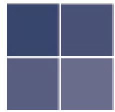

THE ROSS CENTER
FOR ANXIETY & RELATED DISORDERS, LLC

Dear Patient:

Welcome to our practice. We are delighted that you have chosen us to provide health care to you and/or your family. Please know that we will do our best to provide your care in the most comfortable and efficient way possible. We have put policies into place that we feel allow us to do just that, and we appreciate your looking over them and letting us know if you have questions.

I, the undersigned, have reviewed the policies and procedures of The Ross Center. My questions have been answered. I understand that an initial evaluation is not a guarantee of acceptance into treatment; a decision which will be made after the evaluation period. I understand that successful treatment depends on many factors and that The Ross Center provides no guarantee that treatment will be successful.

Additionally, I acknowledge and agree that I have reviewed The Ross Center's Notice of Privacy Practices.

I am aware of the cancellation policy of The Ross Center and agree to its terms.

In addition, I _____ do, _____do *not* give The Ross Center permission to contact my referring physician/therapist to apprise them of my diagnosis and treatment plan.

Referring physician/therapist:

Name: ________________________________

Address: ________________________________

____

Telephone: ________________________________

____________________________	______________________	_________________
Patient's Name (Please Print)	Signature of Patient (or Parent, if a Minor)	Date

POLICIES AND PROCEDURES

CONTACTING THE ROSS CENTER

Routine calls are to be left on your provider's voice mailbox by calling the main number and following the prompts. Messages left on your provider's voice mail will be returned by the next business day, or in accordance with the policy stated on your provider's outgoing message. Please contact the receptionist if you have not heard back from your provider. Messages involving clinical matters should be left directly on your provider's voice mail box and not with the receptionist.

In the event of a life-threatening emergency, please call 911 or proceed to your nearest emergency room. After assuring patient safety, please contact your provider(s). You may leave a voice message for them and then use the emergency number provided to you in session or on their voice mail.

If personal contact information (i.e., address or telephone number) changes, it is the patient's responsibility to inform us of these changes as soon as possible so as not to miss appointment reminder calls, etc. The Ross Center will not be responsible for charges associated with such changes.

Email/ Cellular Phone Use: Use of email between patient and provider is up to the discretion of each provider. Contact with the reception staff via email should be limited to prescription refill requests and appointment scheduling issues. Please be aware that email transmission can fail to be properly delivered or subject to interception, delay, unauthorized amendment or viruses. The Ross Center will not accept liability for such errors. By using email with The Ross Center you agree to these terms. Appointment cancellations and urgent messages should NOT be communicated via email. Cellular phone communication is also subject to interception and is not guaranteed to be a confidential means of communication with your provider or the staff of The Ross Center.

Scheduling of appointments is handled by the reception staff for all providers.

FEES

All fees are due in full at the time of service. The Ross Center does not accept reassignment of benefits from any insurance company and does not bill insurance companies directly. We will provide you with a receipt which you may choose to submit to your insurance company for reimbursement. It will include all of the information typically requested by insurance companies.

If you have **Medicare** or **Medicaid** please inform us immediately. We do not participate with these plans and patients seen at The Ross Center **cannot** submit our receipts to these companies for reimbursement.

If you would like to keep a credit card on file, you may do so; however, it is the patient's responsibility to inform us of any change in credit card information such as expiration date, etc., to avoid declined charges. Any returned check fees are also the responsibility of the patient.

The Ross Center reserves the right to refer past due accounts of 90 days or more to a collection agency. This may require disclosure of otherwise confidential patient information. The patient will also be held responsible for any legal fees and court costs incurred by The Ross Center in securing payment.

Your provider may charge a pro-rated fee for preparation of medical reports, review of records, pre-authorization of care, letters prepared for third parties, and emergency medication requests. You will be informed of the charges at the time of service.

APPOINTMENTS

Your scheduled appointment time is reserved for you. If you arrive late, your appointment will likely be shortened by that amount of time. Please try to arrive punctually to get the full benefit of your session.

Phone Sessions: Many of our providers will offer phone sessions to patients at the regular rate. This service is offered on an individual basis. **Please be aware that the procedure code for the service is different than for an in-office appointment and insurance coverage may not be available depending on your particular plan.** It is the patient's responsibility to clarify this in advance with their insurance carrier. Phone calls lasting in excess of 5 minutes will be pro-rated at the regular rate.

Travel Time: Travel time for sessions that take place away from the office will be pro-rated and billed at the regular therapy rate.

Cancellations: In the event that a patient needs to cancel an appointment, notification must be given **twenty-four (24) business hours** prior to the scheduled appointment time to avoid being charged for the full appointment. The receptionist should be notified directly via phone call or voice mail message.

TERMINATION OF TREATMENT

Patients of The Ross Center who have not seen their provider for ninety (90) days (or within the mutually agreed upon time at the last session, if longer than 90 days), will be considered inactive and will have their file closed, thereby ending any provider-patient responsibility on the part of The Ross Center. Please be assured that anyone wishing to return for treatment can do so and their file will be reopened and activated.

PRESCRIPTION REFILL REQUESTS

All prescription refills should be requested at least 3 days in advance, as the doctor must be available to approve the refill. **Please be sure to get refills at your appointment that will last until your next appointment time**; you will be responsible for ensuring that the appointment is scheduled in a timely fashion so as to avoid running out of medication. You must request a refill by asking your pharmacist to fax a request to us at 202-363-2383. If you are unable to do so, you may leave a message with the receptionist.

Refills for Schedule II medications (such as stimulants, ie Ritalin or Adderall) must, by law, be presented to the pharmacies in hard copy. These prescriptions and any others needing to be provided in hard copy require **one week's notice**. These prescriptions will need to be picked up at The Ross Center, or will be mailed via Fed Ex at the patient's expense.

Refills that are urgent and need to be called in with less than 24 hours' notice will be handled as quickly as possible. However, we will reserve the right to charge a $25 fee for this service.

It is the policy of The Ross Center that patients on medication be seen at regular intervals to ensure patient safety. Please do not stop your medication without speaking to your doctor first, as certain medications can have discontinuation syndromes.

CONFIDENTIALITY

Provider-patient communication is governed by many rules of confidentiality. In particular, provider-patient communication is confidential with the exception of circumstances which may result in harm to the patient or another individual.

With respect to charts and written communication, The Ross Center maintains patient records that are not released to anyone without the consent of the patient (or his/her family if the patient is a minor). Patient records/files are retained for the statutory period at a minimum. Copies of charts (or treatment summaries in the case of request for psychotherapy notes) will be made available as necessary for a minimal fee.

VACATION COVERAGE

In the event that your provider goes on a vacation, a covering provider from The Ross Center will be available to you. Your provider's voicemail will have detailed information as to length of absence and means of contacting the covering provider.

MISCELLANEOUS

Due to federal law, your status as an active patient of **Drs. Daniel Pine** will preclude your participation in National Institute of Mental Health-sponsored studies. This is true only for patients of this specific doctor.

Additionally, if you are an employee of or a dependent of an employee of the State Department, you cannot be treated at The Ross Center by Dr. Enrico Suardi.

Revised 3/27/2015

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact our privacy contact, Mary E. Salcedo, MD at 202-363-1010.

This Notice of Privacy Practices tells you how we may use and disclose your protected health information to treat you, bill for the care we provide, and operate our practice in a business–like manner. It also explains when we may use or disclose patient health information to comply with various laws. "Protected health information" ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices.

We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to receive payment for your health care bills and to support the operation of the physician's practice. The Ross Center will limit its own uses and disclosures of PHI to the minimum amount of information necessary to accomplish the purpose at hand.

Uses and Disclosures of Protected Health Information for Treatment, Payment and Healthcare Operations

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will also disclose PHI to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend and have provided for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we often are required to provide written medical documentation to support services provided to you.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We will share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use your name and address to send you a newsletter about our practice and the services we offer. We may also use your PHI to provide you with information about treatment alternatives or other health-related benefits and services that are relevant to your condition. We will, under no circumstances, sell our patient lists to any third party.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures of Protected Health Information for Public Policy Purposes

We may use or disclose your PHI in the following situations:

Required By Law: We may use or disclose your PHI to the extent that such use or disclosure is required by law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI about you in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal to the extent such disclosure is expressly authorized. We may also disclose PHI about you in response to a subpoena, discovery request or other lawful process., provided appropriate steps have been taken to notify you or to get a protective order from the court to safeguard your PHI.

Law Enforcement: We may disclose PHI for law enforcement purposes, such as: (1) legal processes and otherwise required by law, (2) pertaining to victims of a crime, (3) suspicion that death has occurred as a result of criminal conduct, (4) in the event that a crime occurs on the premises of the practice, and (5) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner, medical examiner, or funeral director for identification purposes, as appropriate.

Research: We may disclose your PHI to researchers doing studies based on existing medical records or using existing records to plan a study involving patient treatment when their research has been approved by an institutional review board, which has reviewed the research proposal and established protocols to ensure the privacy of your PHI. If you agree to participate in research involving treatment, you will also be asked to sign an authorization to allow the researcher to use PHI gathered in the study.

Imminent Threats: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military and security purposes.

Workers' Compensation: We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs.

Disclosures to the U.S. Department of Health and Human Services: Under the law, we must make disclosures on request to the Secretary of the Department of Health and Human Services ("HHS") to help HHS determine whether we are operating incominvestigate or determine our compliance with federal laws that protect the privacy of your health information.

Other Uses and Disclosures of Protected Health Information:

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke an authorization at any time, in writing, except to the extent that your physician or the practice has taken an action in reliance on the uses or disclosures permitted under that authorization.

2. YOUR RIGHTS

You have the right to inspect and copy your PHI. You may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and/or the practice uses for making decisions about you. You may be charged a fee for the copying at the rates prescribed under local law. To obtain access to your medical record, you must submit a written request for such record to the Privacy Officer.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You must submit the request in writing and describe the specific restriction requested and to whom you want the restriction to apply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable anticipation of litigation, or information governed by certain federal laws pertaining to laboratory testing quality.

Your physician is not required to agree to a restriction that you may request. We may deny your request for an amendment if we believe the information at issue is accurate and complete or if we did not create the information originally. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

You may have the right to have your physician amend your protected health information. You may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. We will not delete information from your medical record, but we may make adjustments or note corrections to the record, if so agreed. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations, as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 13, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us at any time.

3. COMPLAINTS

You may complain to us or to the Region III, Office for Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111 or e-mail : OCRComplaint@hhs.gov , if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Dr. Salcedo, at 202-363-1010 for further information about the complaint process.

This notice was published and becomes effective on September 2, 2011

THE ROSS CENTER
FOR ANXIETY & RELATED DISORDERS, LLC

EMAIL CONSENT FORM

PATIENT NAME ____________________________ **EMAIL ADDRESS**____________________________

RISK OF USING EMAIL

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily misaddress an e-mail.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Back-up copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. E-mail can be used as evidence in court

CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by the Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to in any period of time. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
e. If the patient's e-mail requires or invites a response from the Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
f. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
g. The patient is responsible for informing Provider of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
h. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
i. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
j. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.
b. Inform Provider of changes in his/her e-mail address.
c. Put the patient's name in the body of the e-mail.
d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question)
e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to Provider
f. Inform Provider that the patient received an e-mail from the Provider.
g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
h. Withdraw consent only by e-mail or written communication with Provider.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had are answered.

Signature________________________

Date____________________________

THE ROSS CENTER
FOR ANXIETY & RELATED DISORDERS, LLC

CHILD/ADOLESCENT INFORMATION

Patient_________________________________DOB_____________Date____________________

Address_________________________________ City ____________State ________Zip________

Phone: Home__________________________ Cell_________________________________

School___________________________________ Grade______________________________

FAMILY INFORMATION

Parent/Guardian Name ______________________Cell_______________Work________________

Address (if different from patient) ____

Parent/Guardian Name _______________________ Cell______________Work_______________

Address (if different from patient) ____

Names/Ages of Siblings: ____

Guardianship___________________________ Parent Marital Status_________________________

If parents divorced/separated, please briefly describe living arrangement_________________________

____

Email *(please note disclosure below)*____

By providing this email address, I am giving permission for The Ross Center to contact me via email. I understand that email cannot be guaranteed to be secure or error-free, and that information could be corrupted, intercepted, lost, destroyed, arrive late or incomplete, or contain viruses. I understand that The Ross Center does not accept liability for any errors or omissions which may arise as a result of email transmission.

Preferred method of contact: ______Home _____Work _____Cell _____Email

Are you covered by Medicare, Medicaid or Tricare? _________Yes ______No

How did you learn about The Ross Center? ____

Please list the name/number of any other mental health clinicians involved in your child's care:

____
Name Phone Number

____
Name Phone Number

____
Name Phone Number

____
Name Phone Number

THE ROSS CENTER
FOR ANXIETY & RELATED DISORDERS, LLC

Consent to Outpatient Psychotherapy Treatment of a Minor

I,______________________________ , the parent/legal guardian of the minor,

______________________________, consent to outpatient psychotherapy treatment of this minor at The Ross Center for the purposes of addressing mental health symptoms or concerns.

I understand that all information shared with the clinician at The Ross Center is confidential and no information regarding the minor's treatment will be released without my written consent. Verbal consent for limited release of treatment information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality obligation which include the following:

- When there is risk of imminent danger to the minor or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

- When there is suspicion that the minor is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the minor, and to inform the proper authorities.

- When a valid court order is issued for medical records, the clinician and The Ross Center are bound by law to comply with such requests.

I affirm that I am the parent or legal guardian of this minor, and there is no legal bar to my consent for outpatient psychotherapy treatment of this minor. I affirm that I understand and accept the information contained herein and that I have had the opportunity to discuss any concerns with the treating clinician. I acknowledge that I can withdraw my consent to treatment of this minor at any time by sending a written notification to the attention of the treating clinician at The Ross Center

____

Signature of Parent/Guardian Date

____

Signature of Parent/Guardian Date

I have discussed the information contained herein with the minor's parent or guardian.

____

Signature of Treating Clinician Date

Agreement for Group Therapy

As a group member, I have rights and benefits as well as duties, and I understand that some of them are described in this agreement.

The purpose of this group is to provide me with the opportunity to Identify, challenge and change negative thought patterns that make certain things difficult for me.

I agree to:

- Work hard In group by talking about my thoughts and feelings, honestly reporting my behaviors, and following up with the assignments of the group.
- Attending all meetings of the group from start to finish, even if I don't feel like it.
- Apprise the leaders of any emergencies that will keep me from coming to group
- Seek out individual therapy if issues arise that cannot be managed in group therapy alone'

I understand the confidentiality (privacy) is important for all group members and so agree to the following rules:

- First names only are to be used throughout group
- No visitors will be permitted into group
- The use of any recording devices is not permitted in the group
- Any information shared by any member of the group shall not be revealed in any setting outside the group, even if the member's identity is concealed

I have read the points stated above, have discussed them when I was not clear about them, and have had my questions answered fully. I understand and agree to them, as shown by my signature below.

____

Signature of member Date

____

Printed name

____

Signature of Parent/Guardian Date

____

Printed name

Please return a completed and signed copy of this agreement to one of the group's leaders, and you will receive a copy for you to keep.

I, a leader of this group, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____

Signature of leader Date

____

Printed name

SPENCE CHILDREN'S ANXIETY SCALE
(Parent Report)

Your Name:___________________________________ Date:_____________

Your Child's Name:____

BELOW IS A LIST OF ITEMS THAT DESCRIBE CHILDREN. FOR EACH ITEM PLEASE CIRCLE THE RESPONSE THAT BEST DESCRIBES YOUR CHILD. PLEASE ANSWER ALL THE ITEMS.

1. My child worries about things	Never	Sometimes	Often	Always
2. My child is scared of the dark	Never	Sometimes	Often	Always
3. When my child has a problem, she/he complains of having a funny feeling in her/his stomach	Never	Sometimes	Often	Always
4. My child complains of feeling afraid	Never	Sometimes	Often	Always
5. My child would feel afraid of being on her/his own at home	Never	Sometimes	Often	Always
6. My child is scared of she/he has to take a test	Never	Sometimes	Often	Always
7. My child is afraid when she/he has to use public toilets or bathrooms	Never	Sometimes	Often	Always
8. My child worries about being away from us/me	Never	Sometimes	Often	Always
9. My child feels afraid that she/he will make a fool of herself/himself in front of people	Never	Sometimes	Often	Always
10. My child worries that she/he will do badly at school	Never	Sometimes	Often	Always
11. My child worries that something awful will happen to someone in our family	Never	Sometimes	Often	Always
12. My child complains of sudden feeling as if she/he can't breathe when there is no reason for this	Never	Sometimes	Often	Always
13. My child has to keep checking she/he has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
14. My child is scared if she/he has to sleep on her/his own	Never	Sometimes	Often	Always
15. My child has trouble going to school in the mornings because she/he feels nervous or afraid	Never	Sometimes	Often	Always
16. My child is scared of dogs	Never	Sometimes	Often	Always
17. My child can't seem to get bad or silly thoughts out of her/his head	Never	Sometimes	Often	Always
18. When my child has a problem she/he complains of her/his heart beating really fast	Never	Sometimes	Often	Always
19. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
20. My child worries that something bad will happen to her/him	Never	Sometimes	Often	Always

21. My child is scared of going to the doctor or dentist	Never	Sometimes	Often	Always
22. When my child has a problem, she/he feels shaky	Never	Sometimes	Often	Always
23. My child is scared of heights (eg. Being at the top of a cliff)	Never	Sometimes	Often	Always
24. My child has to think special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
25. My child feels scared if she/he has to travel in the car, or on a bus or train	Never	Sometimes	Often	Always
26. My child worries what other people think of her/him	Never	Sometimes	Often	Always
27. My child is afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
28. All of a sudden my child feels really scared for no reason at all	Never	Sometimes	Often	Always
29. My child is scared of insects or spiders	Never	Sometimes	Often	Always
30. My child complains of suddenly becoming dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
31. My child feels afraid when she/he has to talk in front of the class	Never	Sometimes	Often	Always
32. My child complains of her/his heart suddenly starting to beat too quickly for no reason	Never	Sometimes	Often	Always
33. My child worries that she/he will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
34. My child is afraid of being in small closed places, like tunnels or small rooms	Never	Sometimes	Often	Always
35. My child has to do something over and over again (like washing her/his hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
36. My child gets bothered by bad or silly thoughts or pictures in her/his head	Never	Sometimes	Often	Always
37. My child has to do certain things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
38. My child would feel scared if she/he had to stay away from home overnight	Never	Sometimes	Often	Always
39. Is there anything else that your child is really afraid of?	Never	Sometimes	Often	Always
Please write down what it is and fill out how often she/he is afraid of this thing:				
	Never	Sometimes	Often	Always
	Never	Sometimes	Often	Always
	Never	Sometimes	Often	Always

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