24-Hour Cancellation Policy Reminder

Like most health care agencies' policies these days, as outlined in the signed Outpatient Service Contract and the signed Intake Form p. 3, we ask that should you be unable to keep your scheduled appointments, that you provide your therapist on their voice mail, with 24 hours or 1 day in advance notice. For example, if your appointment is at 5 PM on a given day, the cancellation must be made by 5 PM on the PRIOR day. We ask this so that where possible, a potential client who may be on a waiting list or need the time slot can be offered the appointment, as well as to be considerate of the therapist's and agency's time as we cannot bill an insurance company for a session that has not occurred as the fee schedule is based on kept appointments. We try to be as reasonable as possible with this policy as we fully understand that emergencies occur and 'life happens.' Therefore, provided that a person served is consistent with keeping their appointments, we can be flexible with approximately one late cancellation or no-show within a treatment quarter, or a three month period. When that occurs, we will only ask for the person served to pay their insurance co-payment, whatever that is, and if there is no copayment, we will ask for the average, which is $25.00, to be paid in full upon the next scheduled session along with the copay for that session. This accommodation will be afforded for the first time late cancellation, as normally our full billable rate is $150.00 per initial assessment and $140.00 for each follow up session.

Should a second late cancellation or no-show occur within a three month period, even if it is an emergency and cannot be helped, we will still require a cancellation fee, but again, we try to be reasonable and rather than ask the person served for the full amount of $140.00, we will require the least amount for which we are reimbursed by any one insurance policy which is $60.00 to be paid in full upon the next scheduled session along with the copay for that session.

Upon the third cancellation within a three month period, even if it is an emergency and cannot be helped, we will require the full amount of our billed sessions, which is $140.00 which may be paid over the course of the next two scheduled sessions if needed.

Since I have taken time to consider this policy to be as fair as possible there will be NO EXCEPTIONS.

If you have any questions or concerns do not hesitate to ask your therapist or call me directly, Renee Simone, LICSW, LADC I, ICDP at either (413) 536-1918 or (413) 388-1552.

I appreciate your consideration in this matter.

Renee Simone, MSW, LICSW, LADC I
Owner Change Happens, INC

☐ By checking this box I state that I understand and agree with the need for the information and as part of informed consent to my treatment. I also understand that I have a right to receive a hard copy of any of these forms upon request, especially forms that bear my signature.

Change Happens, INC
Behavioral Health Services
Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient / Client Name: _____

D.O.B _____

Last four digits of SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of CHANGE HAPPENS, INC Notice of Privacy Practices and of clients' rights along with the limitations on confidentiality. I understand that if I have any questions regarding the Notice or my privacy rights or responsibilities I can contact Renee Simone, LICSW, LADC I at 71 Mary Street Chicopee, MA 01020.

1111

_____

Signature of Patient / Client **Date**

_____

Signature of Parent, Guardian or Legal Representative* **Date**

***If you are signing as a personal or legal representative of an individual, please describe your legal authority to act for this individual (i.e., power of attorney, health care surrogate, etc.)**

- **Patient / Client refuses to Acknowledge Receipt**

_____

Signature of Staff Member **Date**

CHANGE HAPPENS, INC

The Slower You Go, The Faster You Get There.

71 Mary St., Chicopee, MA 01020
Ph: (413) 536-1918
661 Front St., Chicopee, MA 01013
Ph: (413) 592-8515; f: (413) 532-4805
journeymker@verizon.net

OUTPATIENT SERVICES CONTRACT

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

We normally conduct an evaluation that will last from 1 to 2 sessions. During this time, we can both decide if we are the best persons to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one 45 to 50-minute session (one appointment hour of 45-50 minutes duration) per week or per every couple of weeks, at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to be responsible for the time in accordance with the outlined policy attached to this contract unless a late cancellation or no show fee is prohibited by your insurance policy. [If it is possible, we will try to find another time to reschedule the appointment.]

PROFESSIONAL FEES

Our hourly fee is $150 for the initial assessment and $140 for individual, couples or family sessions, and $30 for group sessions. In addition to weekly appointments, we charge this amount for other professional

services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party. [Because of the difficulty of legal involvement, we charge $200 per hour for preparation and attendance at any legal proceeding.]

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan.] If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course we will provide you with whatever information we can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow us to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.] You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before

you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

CONTACTING US

We are often not immediately available by telephone. While we are usually in the office between 9 AM and 5 PM, we probably will not answer the phone when we are with a patient. When we are unavailable, our telephone is answered by voice mail, that we monitor frequently. We will make every effort to return your call on the same day you make it. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychiatrist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging, in which case we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, we will provide them only with general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of my concern. We will also provide them with a summary of your treatment when it is complete. Before giving them any information, we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we am prepared to discuss. [At the end of your treatment, we will prepare a summary of our work together for your parents, and we will discuss it before we send it to them.]

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony if he/she determines that the issues demand it. There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child [elderly person, or disabled person] is being abused, we must file a report with the appropriate state agency. If we believe that a patient is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in our practice. If a similar situation occurs, we

will make every effort to fully discuss it with you before taking any action. We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patients. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will obtain written authorization from you if you don't object. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys. [If you request, we will provide you with relevant portions or summaries of the state laws regarding these issues.] More specific information regarding confidentiality is included in Change Happens, INC Privacy Practices in your intake packet which requires an additional separate signature.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Rev. 3/11

_____ _____

Signature of Patient / Guardian if Minor Date

_____ _____

Signature of Therapist / Witness Date

If refusing to sign, please indicate the reason for this below, sign and date.

_____ _____

Signature of Patient / Guardian if Minor Date

_____ _____

Signature of Therapist / Witness Date

Change Happens, INC 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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child, Elder, or Disabled Person Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child, elder, or disabled person abuse or neglect or risk of harm to self or others.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer Renee Simone, LICSW, LADC I, Owner at 71 Mary St., Chicopee, MA 01020.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You will also be informed of the risks to maintaining your PHI outside of the secure environment and will also be asked to sign a written release of information to release your PHI to yourself.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer Renee Simone, LICSW, LADC I at 71 Mary St., Chicopee, MA 01020, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is March 2010.

☐ By checking this box I state that I understand and agree with the need for the information and as part of informed consent to my treatment. I also understand that I have a right to receive a hard copy of any of these forms upon request, especially forms that bear my signature.

First Name Last Name

Change Happens, INC
Behavioral Health Services
-Emergency Contact Information-

Date: (updated as indicated)_____

MEMBER INFORMATION:
Name_____
Street Address:_____
City/State/Zip:_____
DOB:_____
Preferred Phone:_____
Marital Status:_____
Primary/Preferred Language:_____
Interpreter Needed: [ ] yes [ ] no

CHILDREN/ADOLESCENTS:
Parent/Guardian:_____
Street Address:_____
City/State/Zip:_____
Home Telephone:_____
Work Telephone:_____

MEDICAL INFORMATION:
PCP:_____
Address:_____
Telephone:_____
Date of Last Physical:_____
ALLERGIES:_____

EMERGENCY CONTACT:
Name:_____
Relationship:_____
Street Address:_____
City/ State/Zip:_____
Preferred Phone:_____

Change Happens, INC

INTAKE PERSONAL AND INSURANCE INFORMATION

PERSONAL INFORMATION

Name **D.O.B.**

Address **Gender Orientation**

test

City / State / Zip

Marital Status

Preferred Contact Number(s)

Last Four Digits of SSN

RESPONSIBLE PARTY

(Fill in if under 18 or if someone other than client is responsible for payment and / or is the subscriber)

Name **D.O.B.**

Address

City / State / Zip

Preferred Contact Number(s)

Relationship to Patient

FINANCIAL POLICY

Appointments cancelled with less than 24 hours notice will be charged to me in accordance with the cancellation policy schedule unless prohibited due to the insurance payors policy. I have been offered a copy of the policy and I understand and agree to the above and understand and agree to the information set forth in the Outpatient Services Contract.

_____

Patient/Parent/Guardian/Legal Representative Signature **Date**

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR INSURANCE

I authorize the use or disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not ha health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand as set forth in the Outpatient Services Contract that my health insurance benefits are designed to help with part or all reimbursement and that it is my responsibility to verify and / or obtain authorization if required, meet any / all deductibles or co-pays, and to pay for services not covered by my health insurance. I authorize payment of medical benefits to my provider for services performed.

_____

Patient/Parent/Guardian/Legal Representative Signature **Date**

Change Happens, INC
Behavioral Health Services
-Notice of Member Rights-
(taken from DMH regulations 104 CMR 28.00)

1. You have the right to be free from discrimination on the basis of race, creed, religion, sex, sexual orientation, age, physical or mental disability.
2. You have the right to religious freedom and practice.
3. You have the right to be represented by an attorney or advocate of your own choice.
4. You have the right to be protected from commercial exploitation.
5. You have the right to a humane and psychological and physical environment.
6. You have the right to receive and inspect a copy of your case record, and to request amendments to your case record.
7. You have the right to confidentiality of your case record.
8. You have the right to participate in your treatment planning and to give informed consent to recommend therapy, including medication.
9. You have a right to be free from unreasonable searches.
10. You have the right to file complaints without fear of retaliation.
11. You have the right to vote.

If you believe that your rights or the rights of another client has been violate you should notify your therapist or the Owner as outlined in *How to File A Complaint Form.* You can ask for a copy of this form from your therapist at any time.

_____
Member / Parent / Guardian / Legal Representative Signature

_____
Date

Change Happens, INC
Behavioral Health Services
-Orientation to Treatment Information-

I have received the following forms:

- ☐ **After Hours Instruction**
- ☐ **How to File a Complaint**
- ☐ **Privacy Practices Notification**
- ☐ **Patient Rights**
- ☐ **Outpatient Services Contract**
- ☐ **Use of Technology**
- ☐ **Other** _____

_____
Member / Parent / Guardian / Legal Representative Signature

_____
Date

Schwartz Outcome Scale-10

Instructions: Please respond to each statement by circling the number that best fits how you have generally felt over the last 7 days. There are no right or wrong responses. Often the first answer that comes to mind is best.

1. Given my current physical condition, I am satisfied with what I can do.

0	1	2	3	4	5	6
Never						All or nearly all of the time

2. I have confidence in my ability to sustain important relationships.

0	1	2	3	4	5	6
Never						All or nearly all of the time

3. I feel hopeful about my future.

0	1	2	3	4	5	6
Never						All or nearly all of the time

4. I am often interested and excited about things in my life

0	1	2	3	4	5	6
Never						All or nearly all of the time

5. I am able to have fun.

0	1	2	3	4	5	6
Never						All or nearly all of the time

6. I am generally satisfied with my psychological health.

0	1	2	3	4	5	6
Never						All or nearly all of the time

7. I am able to forgive myself for my failures.

0	1	2	3	4	5	6
Never						All or nearly all of the time

8. My life is progressing according to my expectations.

0	1	2	3	4	5	6
Never						All or nearly all of the time

9. I am able to handle conflicts with others.

0	1	2	3	4	5	6
Never						All or nearly all of the time

10. I have peace of mind.

0	1	2	3	4	5	6
Never						All or nearly all of the time