SAGINAW Psychological SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

Welcome to Saginaw Psychological Services Inc. (SPSI)

Client Information:

Last Name:	First Name:
Today's Date:	Date of Birth:

Thank you for choosing SPSI. We are a member of the Bay-Arenac Behavioral Health Authority (BABHA), Saginaw Community Mental Health Authority (SCCMHA) Provider Network, as well as many other contract providers. Our purpose is to provide the highest quality behavioral health and substance use treatment in a safe and positive environment. All persons served and visitors are asked to refrain from using vulgar language in common areas of the building and are expected to treat SPSI staff and other persons in the building with respect.

Here are some facts and expectations regarding your services

- You will meet with a therapist, psychologist, or case manager and will receive a comprehensive assessment to understand your needs and help us determine which of our programs is the right program for you.
- Your worker may make a referral to either our medical provider for a psychiatric evaluation and medication management services or BABHA/SCCMHA, if that is appropriate.
- Your worker will help you develop a person-centered plan, which is based upon your needs. A person-centered plan must be completed for you to receive services, including medication management.

We look forward to your full cooperation in services. Failure to participate in the program may result in your services ending, including medication services. You will be notified in advance if you are at risk of services ending. If your services end because of lack of participation, there is a grievance and appeals process available through the BABHA/SCCMHA customer service department.

If you are involved in medication management services and you have fully participated in your program, and you are 18 years old or older, you may be able to graduate to the medication only service with your assigned medication provider. This will occur only if your assigned SPSI worker recommends this and the treating medical provider gives their approval. In order to fully comply with this program standard, you would still need to sign appropriate consents once a year. SPSI reserves the right to take you out of this program and switch you into traditional services at any time the prescriber deems necessary. Examples of such circumstances could include psychiatric hospitalization SUD rehabilitation, overall functioning decreases and/or other situations that indicate necessity for a higher level of care.

- All legally prescribed medications brought into our facility must be in their original containers with the original labels attached.
- Any person entering the building possessing a weapon and/or illegal drugs, or behaving in a threatening manner will be asked to leave and may return when he/she no longer has a weapon, has illegal drugs on his/her person, and/or can demonstrate they have regained control of their behavior enough to attend a meeting. If at any time a person is, or becomes, a threat to himself/herself and/or to others, local authorities will be contacted for immediate assistance.

In the event of an emergency, it is the responsibility of SPSI staff to ensure the safety of all persons served and visitors. Your worker is familiar with the building, including the location of emergency exits and first aid kits. In the event of an emergency, you will be directed and escorted to the appropriate safe area. If physical emergency care is necessary, arrangements for treatment will be made.
Thank you for choosing SPSI to address your recovery needs. Your cooperation with our program rules and expectation is greatly appreciated. We look forward to assisting you with your goals. Feel free to discuss any questions or concerns with your worker or their supervisor.

Signatures Attesting to Responsibility & Service Agreement:

Client/Guardian Signature	Date
Witness Signature	Date

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Notice of Privacy Practices Acknowledgement and Receipt of Client Orientation

Client Information:

Last Name: _____First Name: _____

Today's Date: _____Date of Birth: _____

Current Address: _____

Current Phone Number: _____

Additional Phone Numbers: _____

Current Email Address: _____

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand SPSI's Notice of Privacy Practices, which provides a more complete description of the uses and disclosures of my health information. I understand that SPSI has the right to change its Notice of Privacy Practices from time to time and that I may contact SPSI at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that SPSI restrict how my private information is used or disclosed to carry out treatment, billing/payment or health care operations. I also understand that SPSI is not required to agree to my requested restrictions, but if SPSI does agree, then SPSI is bound to abide by such restrictions.

Signatures Attesting to Notice of Privacy Practices Acknowledgement:

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Consent to Financial Responsibility and Service Agreement

Client Information:

Last Name:	First Name:
Today's Date:	Email Address:

Financial Policy: All insurance policies, third party insurance administrator and court order payment documents are contracts and / or orders between you and the party listed on those documents. SPSI will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, co-insurance, covered charges, secondary insurances, usual and customary charges etc. other than to supply information as necessary.

- You are ultimately responsible for paying all co-payment, co-insurance, deductibles, and non-covered services at the time of the services and not to extend beyond **30 days** of the date of service.
- Failure to pay your portion of services rendered will be reported to your insurance carrier and/or a collection agency.
- The fees listed below must be paid at the time of service:
    - Forms Completion: Disability, insurance, travel, release from work, that are not required by most insurance plans or employers.
        - If you require a member of your care team to complete one of these forms or write a letter, there will be a **$25** charge in addition to your office visit charge.
    - Medical Records: We will provide to you, upon written request, a copy of your medical records.
        - We charge a base fee of **$31.54** as well **$1.58** for the first 20 pages**, $0.79** per pages 21-50 and **$0.32** per pages 51+
    - There is a **$40** fee if your appointment is not canceled within 24 hours prior to the appointment.
    - Late fees: balances not paid within 60 days will result in a **$10** late fee per month.

Assignment of Benefits-Financial Agreement:
I hereby give lifetime authorization for the payment of insurance benefits to be made directly to Saginaw Psychological Services Inc. (SPSI) for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

Insurance Status Agreement
I hereby further agree that at all times during my treatment at SPSI I will provide all updated insurance coverage information. I understand that if I fail to give SPSI information regarding other primary or secondary insurances I have that I will be fully financially responsible for all monies SPSI is unable to collect from Medicaid, Medicare and/or BABHA/SCCMHA directly.

Primary Insurance Company: Name of Insurance Company _____
Subscriber ID# _____ Group # _____
Policyholder Full Name: _____ Date of Birth: _____
Relationship to You: Self Spouse Child Other: _____
Secondary Insurance Company: Name of Insurance Company _____
Subscriber ID # _____ Group # _____
Policyholder Full Name: _____ Date of Birth: _____
Relationship to You: Self Spouse Child Other: _____

I understand that any portion of my medical bills that are not covered by insurance will be billed to me at the email/address I have provided. If I do not receive a bill, I understand I may request one by contacting SPSI. I understand it is my responsibility to inform SPSI when my email/address changes or my insurance policy changes. Non-compliance or defaulting on payments may result in denial of service and/or legal claim against me for non-payment. I further agree that a photocopy of this agreement shall be as valid as the original.

Signatures Attesting to My Financial Responsibility & Service Agreement:

Client/Guardian Signature	Date
Witness Signature	Date

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Consent to Coordination of Care

Client Information:

Last Name: _____First Name: _____

Today's Date: _____ Date of Birth: _____

Family Doctor's Printed Name: _____

Family Doctor's Address: _____

Family Doctor's Telephone Number: _____

Family Doctor's Fax Number: _____

I **do** / **do not** (please circle one)

authorize SPSI, my behavioral health care provider and my family doctor (identified and named above) to exchange information regarding my mental health/substance abuse treatment, medical health, psychiatric and therapy records for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care, psychiatric care or substance abuse and/or treatment (as protected under 42 CFR Part) such as diagnosis and treatment plan and medical information, including information regarding the presence or absence of HIV/AIDS. I understand that this authorization shall remain in effect for one year from the date of my signature below. I understand that I may revoke this authorization at any time by providing written notice to SPSI. I further understand that it is my responsibility to notify this provider if I choose to change my family doctor.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Behavior Health Provider Information (to be completed by provider)

Treating SPSI Provider: _____

DSM V Diagnosis Code and Name: _____

Treatment Modalities:

Psychotherapy: ___ Individual ___ Group ___ Family Frequency of Visits: _____

Notes: _____

Medication Management By: _____

(Physician's name, phone, fax)

If authorization is given, a copy of this form and a medication list, if applicable will be sent to the Family Doctor.

Reviewed &Updated January 2026

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Consent to Release Medical Information

Client Information:
Last Name: _____First Name: _____
Today's Date: _____ Date of Birth: _____

I authorize SPSI to release and/or obtain medical and/or mental health information contained in my records as specified below and to provide access to, or provide such photocopies, as may be requested of the person or organization and to the extent and nature listed below, subject to the conditions listed below.

I authorize SPSI to SHARE and RECEIVE information from the following:

PRINTED NAME	RELATIONSHIP	PHONE NUMBER
1		
2		
3		
4		

WILL COVER ONE YEAR SERVICE RANGE unless specified differently: _____

Place a "x" next to the information to provide:

	Psychological Evaluation		Treatment Summary		Medication Review(s)
	Psychiatric Evaluation		Discharge Summary		Discharge Instructions
	Lab Work Results		Clinical Psychotherapy Note(s)		
	Other (specify)				

Identified information should be disclosed: | | **VERBALLY** | | **HARD COPY**

Place a "x" to authorize disclosure of all information related to: | | HIV/AIDS | | Substance Use

I understand that my records are protected by Federal and State Confidentiality Laws, and cannot be further disclosed without my written authorization, unless release is required by other State or Federal regulations. I understand that there is a possibility the information may be re-disclosed by the recipient of the information and will no longer be protected by the Privacy Rules. I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits. I understand that I may inspect or copy any information released under this authorization. I understand this authorization will expire upon termination of services, or one year from the date of signature. I further understand that, per the Privacy Notice, I may revoke this authorization at any time by notifying Saginaw Psychological Services, Inc, in writing, but any previously disclosed information would be excluded from my revocation request.

Signatures Attesting to My Consent to Release of Information:

Client: _____ Date: _____

Witness: _____ Date: _____

— —

IF YOU LISTED ANYONE ABOVE, PLEASE DO NOT SIGN THE DECLINE LINE BELOW:

There is no one whom I want SPSI to share information with at this time.
I **DECLINE** this form: Signature: _____ Date: _____
I would like to REVOKE this form. As of today's date, _____, SPSI no longer has permission to share my information. Signature: _____

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Consent to TeleMedicine Services

TeleMedicine involves the use of electronic communication to enable health care and mental health providers, at locations different from their consumers, to engage in therapeutic services or share medical information for the purpose of maintaining and improving care. The information may be used for diagnosis, therapy, follow up and/or education. While our best efforts are made to safeguard privacy and confidentiality, there is inherent risk in this modality.

Client Information:

Last Name: _____First Name: _____

Today's Date: _____ Date of Birth: _____

I am providing my consent to engage in TeleMedicine with SPSI as a part of the behavioral health services I may receive. I understand that TeleMedicine psychotherapy may include: mental health evaluation, assessment, consultation, treatment planning and therapy. TeleMedicine will occur primarily through interactive audio, video and telephone.

By signing this form, I understand and consent to the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to TeleMedicine; this means that no information obtained in the use of TeleMedicine which identifies me will be disclosed to researchers or other entities without my expressed written consent.
2. I understand that the limits of confidentiality that apply to treatment also apply to TeleMedicine; these include a mandated reporting of child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law.
3. I understand that I have the right to withhold or withdraw my consent to the use of TeleMedicine in the course of my care at any time without affecting my right to future care or treatment.
4. I understand that TeleMedicine may involve electronic communication of my protected health information (PHI) to other medical practitioners who may be located in other areas.
5. I understand that it is my duty to inform my treatment provider of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that security protocols can fail. Meaning privacy and confidentiality of protected health information cannot be guaranteed with the use of TeleMedicine.
7. I understand that in rare cases, information transmitted may be insufficient to allow for appropriate medical decisions (e.g., poor resolution or sound quality).
8. I understand that delays of treatment may occur due to deficiencies of equipment.
9. I understand that if my provider deems the service he/she is providing to be inappropriate through TeleMedicine, he/she may require the remainder of said services to be carried out in person.
10. I understand that I may expect the anticipated benefits from the use of TeleMedicine in my care, but that no results can be guaranteed or assured.
11. I acknowledge that I have been made aware of the above information regarding TeleMedicine and have reached out to SPSI to answer any questions or concerns I have. I hereby give my informed consent for the use of TeleMedicine with SPSI.

Signatures Attesting to the Consent to TeleMedicine Services:

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Reviewed & Updated January 2026

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Consent to Treatment and Discharge

Client Information:

Last Name: _____First Name: _____

Today's Date: _____ Date of Birth: _____

The following is to be read, completed and signed by the client or the client's parent/guardian. If you are a guardian, please provide a copy of the court paperwork (true copy) for our records, legally stating guardianship award.

I agree to attend psychotherapy and/or case management on an individual, family or group basis, as determined with a therapist or examiner. I have read, reviewed, and understand information provided in the Client Handbook, which includes the SPSI Code of Ethics and my Rights. Any questions I may have had, have been answered satisfactorily.

Throughout the course of my/my family's treatment at SPSI I agree to abide by the following policies:

- I may not leave my minor children unattended in the waiting room.
- I may not leave the building while my child is in a session with their worker.
- I may not bring children into adult therapy sessions.
- I am responsible for making childcare arrangements in advance in order to avoid violating any of the above policies.

Regarding attendance, I understand and agree to the following (limited and reasonable exceptions can be made at the discretion of your worker or with supervisor approval):

- I am expected to cancel all appointments 24 hours in advance of my appointment.
- If I cancel three consecutive appointments my case may be closed.
- Failure to attend two consecutive appointments, without notice, may result in case closure.
- If I arrive 10 minutes late this will result in the appointment being considered a no show.
- Failure to have contact with the agency for 30 days may result in case closure.
- At no time will I be able to have prescriptions phoned in or written for me (or my children) without a face-to-face meeting with an SPSI prescriber. I understand any exceptions to this rule must come directly from my assigned prescriber.
- Failure to work toward person centered plan objectives may result in discharge
- I will be considered for immediate discharge if I engage in any acts or threats of violence or aggression toward staff or other person served.

I understand that in the instance of involuntary discharge, I have the right to appeal the discharge to the clinical program director and recipient rights officer.

The following pertains to both Community Mental Health and Medicaid Clients. I have received a copy of the following supplemental booklets and/or pamphlets.

- Notice of Privacy Practice – containing "Your Rights" booklet information
- Community Mental Health specific brochures and handbooks
- Person Centered Planning brochure

Signatures Attesting to Consent to Provide Treatment and Receipt of the Above Documents:

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date:_____

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HEALTH HISTORY FORM

SmartCare ID: _____ Date: _____

Legal name for insurance purposes: _____

Name (if different than legal): _____

Pronouns: _____

Gender Identity: _____

Sex Assigned at Birth: Male __ Female __ Intersex __

Significant relationship:

____ single
____ married
____ monogamous
____ polyamorous
____ life partnership

Family Doctor's name: _____ phone number: _____
Preferred pharmacy name: _____ phone number: _____
In case of emergency, please contact: _____ phone number: _____
Additional emergency contact: _____ phone number: _____

Who do you want to release information to: _____
Language(s) spoken at home: _____

Are you pregnant: Yes _____ No_____

Are you receiving prenatal care: Yes _____ No_____

Most recent hospitalization: _____ Why: _____

CURRENT MEDICATIONS	**HOW WELL DO THEY WORK ON A SCALE OF 0 TO 10 (0=did not work at all—10=worked very well)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICATIONS	**HOW WELL DID THEY WORK ON A SCALE OF 0 TO 10 (0=did not work at all—10=worked very well)**
_____	_____
_____	_____
_____	_____

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Do you have any allergies or adverse reactions to medications? If yes, please list the medication and the reaction below:

_____ _____
_____ _____
_____ _____
_____ _____

Do you use any substances? Yes __ No__

If Yes, What? _____

Do you have any current or past health conditions? Yes __ No___

If Yes, What? _____

_____

Any surgical procedures: Yes__ No ___

If Yes, What? _____

Research has shown that, in many cases, complimentary approaches to mental health can help increase well-being, ease symptoms of depression, reduce anxiety, and/or aid relaxation. Do you use any of the following to help manage your symptoms?

Meditation: Yes_____ No_____ Art Therapy: Yes ____ No_____

Yoga: Yes_____ No_____ Dance: Yes_____ No_____

Acupuncture: Yes_____ No_____ Tai Chi: Yes_____ No_____

Massage therapy: Yes _____ No_____

Spirituality: Yes ____ No _____

Other: _____

We at SPSI want to make sure that all the information we share with you and present to you is clear and understandable. For this purpose, it is important for us to know if you are able to read all your paperwork, or if you need support in this area. What is your best estimate of your reading grade level?

_____ grade level

_____
Client signature

_____
Witness Signature

Client Name: _____ ID # _____ Date: _____

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide

Have you ever experienced this kind of event?
Yes No

If no, screen total = 0. Please stop here.
If yes, please answer the questions below.

In the past month, have you …

1. had nightmares about the event(s) or thought about the event(s) when you did not want to? Yes No

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Yes No

3. Been constantly on guard, watchful, or easily startled? Yes No

4. Felt numb or detached from people, activities, or your surroundings? Yes No

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? Yes No

PC-PTSD-5 (2015)

National Center for PTSD

*If this screen has any answers of "Yes" then fill out PCL-5

Saginaw Psychological Services
Controlled Substance Agreement

Client Name: _____ Date of Birth: _____

The purpose of this contract is to prevent misunderstandings about the medications you are prescribed by Saginaw Psychological Services, Inc.

You may be prescribed a controlled substance for the treatment of your psychiatric illness(es). It is important that you understand the risks and responsibilities that accompany this treatment. You are ultimately responsible for your physical and emotional health.

This agreement will help you and your prescriber to comply with the law(s) regarding controlled pharmaceuticals.

MAPS (Michigan Automated Prescription System) is a database operated by the State of Michigan that requires all pharmacies to report any controlled substances that they dispense to a patient. This report lists all controlled substances that you pick up from any pharmacy in Michigan and will be monitored to help ensure compliance with this contract.

- I agree not to sell, share or give any medications to another individual.
- I understand that any mishandling of my medications is a violation of this agreement and will result in treatment being terminated (this includes any attempt to alter a prescription).
- I understand that any medical treatment is initially a trial and that continued prescription is based on evidence of benefit. I understand that if my symptoms are not improved or my ability to function is not improved with the medication prescribed, it may be stopped or changed. I will work with my therapist and/or case manager and/or prescriber to maintain realistic expectations of what medication can do for my illness(es). I am agreeable to therapy as a treatment option and know I am responsible to make and keep scheduled appointments.
- I will not attempt to obtain any anti-anxiety medications, sleeping pills or stimulants from another prescriber.
- I will safeguard my medications from loss or theft. I understand that any lost, stolen, or destroyed prescriptions for controlled substances will **NOT** be replaced even with a police report. I will not call the office to report medication lost, stolen or destroyed in effort to obtain refills or additional prescriptions.
- I agree to submit to a urine drug screen if requested by my prescriber.
- I will not use recreational drugs, street drugs or alcohol.
- I understand that if I become pregnant I must notify my prescriber as soon as possible.
- I will report all medications that I am taking (including, but not limited to Methadone, Medical Marijuana, Suboxone and pain medication) to my Saginaw Psychological Services provider. I also agree to sign releases for my prescriber to communicate with all other healthcare providers that are prescribing medications(s) for me.
- I understand that running out of medication early, needing early refills, taking more than prescribed and losing prescriptions may be signs of misuse of the medications and may be reasons for my prescriber to discontinue the medications I have been prescribed.

If you have any questions regarding this information, please request clarification before signing.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Reviewed & Updated January 2026

Client Name: _____ ID Number _____ Date: _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version-Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* *E.g. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it…and I would never go through with it."*		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, given away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***		

Low Risk

Moderate Risk

High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032;
posnerk@nyspi.columbia.edu

Reviewed & Updated January 2026