Intake Packet for Children
(11 years of age and under)

This packet includes:

- ☐ Personal History Questionnaire
- ☐ Office Policy and HIPAA privacy notices signature page. (you do not have to print this out)
- ☐ Signature Page

Link to insurance page: http://willamettehealthandwellness.com/insurance/

If using insurance, call your insurance provider to verify coverage

Questions to ask your insurance company prior to your first visit:

- Is ___(Provider's name)___ a part of my behavioral health *preferred provider* (PP) network?
  - If not a PP: Does my policy included *out of network* (OON) benefits?
- What is my PP or out of network *co-pay*/*co-insurance* and *deductible*?
  - If yes to *deductible*: What amount still needs to be satisfied?
- Does my policy request *authorization*s?
  - If yes: How do I get the *authorization*(s)?
- Does my policy have *limitations*?
  - If yes: What are the *limitations*?

Link to fee schedule: http://willamettehealthandwellness.com/fee-schedule/

Come prepared for your appointment
Patients with incomplete paperwork may be asked to reschedule

Check List

- ☐ Bring the completed Personal History Questionnaire
- ☐ Read the office policies and HIPAA privacy notice
- ☐ Bring completed the signature page.
- ☐ Check our website for address and parking instructions

http://willamettehealthandwellness.com/wp-content/uploads/2013/10/WHW-parking-guide-2016_2_4.pdf

- ☐ Bring medical history information if you feel it would be beneficial
- ☐ Bring insurance card (if using insurance)
- ☐ Bring method of payment (cash, check or debit/credit card)
- ☐ Arrive 10 minutes early

Personal History Questionnaire: Parent/Guardian (child's information)

GENERAL **Today's Date:** / / **Form Completed by:**

I am related to patient through: ☐Birth ☐Adoption ☐Fostering ☐ Other:			
Patient Name:	DOB: / /	Age:	Gender:
Primary Address:	City:	State:	Zip:
Patient Telephone: (home): ( ) -		(cell): ( ) -	
Guardian 1: Name:	Relationship to patient: ☐Mother ☐Father ☐Other:		
☐Address Same as Patient Primary Address			
Primary Address:	City:	State:	Zip:
Telephone: (home): ( ) - (leave blank if same as patient)	(work): ( ) -	(cell): ( ) -	
May we leave a message for you at home? ☐Yes ☐No	At work? ☐Yes ☐No	On cell? ☐Yes ☐No	
May we contact you by email? Email: @	How did you hear about me/us?		
Guardian 2: Name:	Relationship ☐Mother ☐Father ☐Other:		
☐Address Same as Patient Primary Address:			
Primary Address:	City:	State:	Zip:
Telephone: (home): ( ) - (leave blank if same as patient)	(work): ( ) -	(cell): ( ) -	
May we leave a message for you at home? ☐Yes ☐No	At work? ☐Yes ☐No	On cell? ☐Yes ☐No	
May we contact you by email? Email: @			
Alternative Emergency Contact :	Relationship:	Phone: ( ) -	
Preference for appointment reminders: (choose one) ☐Email: @ ☐Call: ( ) - ☐Text: ( ) -			
Name of Current therapist/psychiatric provider:	Phone number: ( ) -		

Please provide the names, ages and relationship of those living in child's home.		
Name	Age	Relationship the child?
Please list names and ages of any siblings not living with child:		

REASON(S) FOR VISIT

Describe your reason for making this appointment for the child:
Describe any recent changes that may contribute to this issue:
Why do you think the child is experiencing this issue?
When did the child first experience this issue?

MENTAL HEALTH/PSYCHIATRIC HISTORY

Please mark any symptoms you believe the child experiences (C)urrently or in the (P)ast.

C	P		C	P		C	P	
☐	☐	depressed/sad mood	☐	☐	muscle tension	☐	☐	relationship problems
☐	☐	reduced interest in activities	☐	☐	excessive worry	☐	☐	eating problems
☐	☐	appetite/weight change	☐	☐	panic symptoms	☐	☐	drug or alcohol problems
☐	☐	frequent crying/tearfulness	☐	☐	boredom	☐	☐	gambling problems
☐	☐	low self-esteem	☐	☐	impulsivity	☐	☐	sexual problems
☐	☐	low motivation	☐	☐	distractibility	☐	☐	computer addiction
☐	☐	social isolation	☐	☐	hyperactivity	☐	☐	problems with pornography
☐	☐	feelings of hopelessness	☐	☐	abnormally elevated mood for several uninterrupted days	☐	☐	work/school problems
☐	☐	seasonal mood changes				☐	☐	parenting problems
☐	☐	loneliness	☐	☐	racing thoughts	☐	☐	suspiciousness/paranoia
☐	☐	feelings of guilt/shame	☐	☐	excessive energy	☐	☐	hearing or seeing things
☐	☐	sleeping too much or too little	☐	☐	flashbacks	other:		
☐	☐	low energy/fatigue	☐	☐	nightmares	other:		
☐	☐	excessive thoughts of death	☐	☐	easily startled	other:		
☐	☐	poor concentration	☐	☐	anger outbursts	other:		
☐	☐	restlessness or feeling on edge/keyed up	☐	☐	excessive fears	other:		
☐	☐	difficulty thinking or making decisions	☐	☐	excessive social discomfort			
☐	☐	irritability	☐	☐	obsessions/compulsions			
☐	☐	frequent anxiety	☐	☐	fear away from home			

Are any of the above symptoms affecting the child's:

☐ability to engage in your normal daily activities ☐work ☐school ☐housing ☐finances ☐recreational activities ☐legal status ☐relationships ☐health ☐happiness ☐spirituality ☐self esteem ☐sexual activity

Has the child been diagnosed with mental health/psychiatric problems in the past? ☐Yes ☐No

Diagnosis	Dates treated or age	By whom

Please list any other outpatient mental health treatment (e.g. therapy, medication management by PCP, medication management by psychiatric provider).

Name/Place	Approximate Dates	Outcome/Experience
	–	
	–	
	–	
	–	

Has the child been psychiatrically hospitalized? ☐Yes ☐No When?

Has the child ever attempted suicide? ☐Yes ☐No When?	How?
Has the child ever engaged in self-harm behavior? ☐Yes ☐No When?	How?

Please list medications the child has previously taken for mental health reasons.			
Name of medication	How long did he/she take?	Dosage	Usefulness/Side Effects/Concerns

Please note presence of family history of mental health problems:			
	Relationship to child	Age of diagnosis?	Treatment?
☐ Depression			
☐ Anxiety			
☐ Schizophrenia			
☐ Bipolar (manic/depression)			
☐ Post-traumatic stress disorder			
☐ Alcohol abuse			
☐ Other substance abuse			
☐ ADHD/ADD			
☐ Suicide or attempted suicide			
☐ Other, specify:			

PREGNANCY/BIRTH

Known substance/toxin exposure during pregnancy? ☐ Cigarettes ☐Alcohol ☐ Drugs – List: Other:	
List any complications during pregnancy:	
Type of delivery: ☐ Vaginal ☐C-Section	Birth Weight: Gestational age at birth:
Did mother experience "baby blues" (postpartum depression)? ☐Yes ☐No	
If yes, did mother seek treatment? ☐Yes ☐No If yes, describe:	

SOCIAL DEVELOPMENT

What was the child like as an infant? :	
Did he/she make eye contact as an infant: ☐ Yes ☐ No	Did he/she seek interaction? ☐ Yes ☐ No
Did he/she demonstrate curiosity about the environment in the first three years? ☐ Yes ☐ No	
What were the child's favorite activities/toys in infancy and toddlerhood? :	
Is there a history of separation anxiety? ☐ Yes ☐ No	Stranger anxiety? ☐ Yes ☐ No
What is the child's activity level in general? ☐ High ☐ Low ☐ Moderate	
How predictable is the child's behavior? ☐ Very predictable ☐ So-So ☐ Unpredictable	
How does the child respond to something new? ☐ Approaches ☐ Withdraws ☐ Watches	
How does the child transition/adapt to novelty or change? ☐ Easily ☐ With difficulty	
How much stimulus is required before the child reacts? ☐ A lot ☐ A little	
Do you find yourself "walking on egg-shells" with him/her? (Please describe):	
Describe the child's persistence: (does he/she continue to work on projects despite obstacles or give up easily?):	
Is the child easily distractible?: ☐ Yes ☐ No	Forgetful?: ☐ Yes ☐ No
How does the child interact with:	
Siblings?:	
Peers?:	
Adults?:	

Child's current play behaviors (check all that apply)

☐ Prefers to play alone	☐ Controlling
☐ Prefers to play alongside others	☐ Aggressive
☐ Prefers to play cooperatively	☐ Can't tolerate losing
☐ Prefers to play with older children	☐ Difficulty taking turns
☐ Cautious	☐ Difficulty sharing
☐ Accident-prone	☐ Reckless

Does he/she have a favorite playmate (other than sibling)? ☐ Yes ☐ No	If Yes, Who?

Describe any concerns you have about his/her social skills or behavior:			
What are his/her current favorite play activities?			
Please indicate how many hours a day the child spends on: TV:	Computer:	Videogames:	Other screens:
Where does the child live? ☐ House ☐ Apartment Other:			
Describe the household: ☐ Messy ☐ Chaotic ☐ Orderly	How much variation in his/her day? ☐ A little ☐ A lot ☐ Varies		
How many times has he/she moved?:			
Is the current neighborhood kid friendly? ☐ Yes ☐ No	If no, why not?		
Family support comes from: ☐ Extended family ☐ Neighbors ☐ Church ☐ Friends ☐ Counselor			
Describe any household chores/duties child is responsible for:			
Who is the primary disciplinarian?	Is discipline consistent? ☐ Yes ☐ No	If No why not?	
Describe form of discipline used at home:		Child's response:	

TRAUMA EXPOSURE (please describe)

Natural disaster:
Loss of parent/significant other:
Domestic Violence:
Abuse/Neglect/Abandonment:

MOTOR DEVELOPMENT

Sat alone age:	Crawled/Creeped age:	Walked alone age:	Picked up small items age:
Undressed self age:	Dressed self age:		
Current motor skills: ☐ Agile ☐ Coordinated ☐ Clumsy ☐ Awkward ☐ Accident prone Describe:			
Describe concerns you have about the child's fine or gross motor skills:			
Hand dominance: ☐ R ☐ L ☐ Neither			
Activity level: ☐ Very High ☐ High ☐ Moderate ☐ Low			

SPEECH AND LANGUAGE DEVELOPMENT

Primary language: Spoke first word age:		Does Child gesture?: ☐ Yes ☐ No		
How does the child let you know his/her wants or needs?:				
How does let you know he/she understands what you say?:				
What percentage of child's speech do you understand?: ☐ 25%	☐ 50%	☐ 75%	☐ 100%	
What percentage do unfamiliar listeners understand?: ☐ 25%	☐ 50%	☐ 75%	☐ 100%	
Past/Current speech therapy:				

FEEDING DEVELOPMENT

Describe any feeding difficulties: Current appetite: ☐ Poor ☐ Fair ☐ Good					
Eating behaviors: ☐ Picky	☐ Overeats	☐ Refuses to eat	☐ Hoards food	☐ Gags/Vomits	☐ Eats non-food items
Do you have any concerns about the child's eating or feeding? ☐ Yes ☐ No Describe:					
List food preferences:					
Does your family eat together at least once a day?: ☐ Yes ☐ No					
Does the child remain seated at the table throughout the meal?: ☐ Yes ☐ No					

At the present the child uses: ☐ Fingers ☐ Fork ☐ Spoon ☐ Bottle ☐ Sippy cup ☐ Open cup

Special Diets (past/present):

What does the child think about his/her weight and shape?

TOILETING/HYGIENE DEVELOPMENT

Is the child currently toilet-trained?: ☐ Yes ☐ No If yes, since what age?:

☐Diapers ☐Pullups ☐ Panties ☐Daytime accidents? ☐ Bedwetting?

Did the child toilet train easily? ☐Yes ☐ No Describe:

Please check all that apply: ☐ Constipation ☐ Frequent loose stool

Describe any resistance to hygiene routines:

SLEEP DEVELOPMENT

Where does the child sleep?: ☐ Solo (alone in own bed) ☐ With parent ☐ With sibling ☐ Other:

Does he/she sleep in a room alone or share a room with siblings/other?: ☐ Yes ☐ No

Bedtime: Average number of hours of sleep each night:

How does he/she wake up?: ☐ Slowly/Reluctantly ☐ Quickly/Eagerly

Does child Nap?: ☐ Yes ☐ No If Yes for how long:

Sleep Disturbances: (check all that apply)

☐Reluctance to go to bed	☐Difficulty getting to sleep
☐Restless during the night	☐Talks/Cries in sleep
☐Bad dreams	☐Snoring/irregular breathing
☐Frequent waking	☐Difficulty getting up in the morning

Describe any other concerns relating to sleep behaviors:

GENERAL HEALTH/MEDICAL HISTORY

Primary Care Provider (PCP) Name:		
PCP Address:	Phone:	FAX:
Approximate Date of Last Medical Visit:	Reason for Visit:	
Allergies to Medication:	Allergies to Other:	
Please list any ongoing medical problems your child has:		

Please list all current prescription medications, over the counter medications, herbal remedies, nutritional supplements:

Name of Medication/Supplement	Dosage/ Frequency	Purpose	Prescribing/Recommending Provider's Name

Review of Systems:

Below please check any of the following health problems that the child is <u>currently</u> experiencing or has experienced in the last three months.

General	☐ Sores that won't heal	**Vascular**
☐ Weight loss or gain	**Neck**	☐ Pain in lower leg when walking
☐ Fatigue	☐ Lumps	☐ Leg cramping
☐ Fever or chills	☐ Swollen glands	**Musculoskeletal**
☐ Weakness	☐ Pain	☐ Muscle or joint pain
☐ Trouble sleeping	☐ Stiffness	☐ Stiffness
Skin	**Breasts**	☐ Back pain
☐ Rashes	☐ Lumps	☐ Redness of joints
☐ Lumps	☐ Pain	☐ Swelling of joints
☐ Itching	☐ Discharge	☐ Trauma
☐ Dryness	☐ Breast feeding (if applicable)	**Neurologic**
☐ Color changes	**Respiratory**	☐ Dizziness
☐ Hair and nail changes	☐ Cough	☐ Fainting
Head	☐ Sputum	☐ Seizures
☐ Headache	☐ Coughing up blood	☐ Weakness
☐ Head injury	☐ Shortness of breath	☐ Numbness
☐ Neck pain	☐ Wheezing	☐ Tingling
Ears	☐ Painful breathing	☐ Tremor
☐ Decreased hearing	**Cardiovascular**	☐ Memory loss
☐ Ringing in ears	☐ Chest pain or discomfort	☐ Incoordination
☐ Earache	☐ Tightness	☐ Feeling of restlessness in legs, especially at night
☐ Drainage	☐ Palpitations	
Eyes	☐ Shortness of breath with activity	☐ Feelings of internal restlessness made worse by medication
☐ Vision loss/change	☐ Difficulty breathing lying down	
☐ Glasses or contacts	☐ Swelling	☐ Involuntary movements of the tongue, lips, mouth
☐ Pain	☐ Sudden awakening from sleep with shortness of breath	
☐ Redness		☐ Involuntary movements of other parts of body. Which ones?
☐ Blurry or double vision	**Gastrointestinal**	
☐ Flashing lights	☐ Swallowing difficulties	☐ Hyper reflexes
☐ Specks	☐ Heartburn	**Hematologic**
☐ Glaucoma	☐ Change in appetite	☐ Bruise easily
☐ Cataracts	☐ Nausea	☐ Bleed easily
Nose	☐ Change in bowel habits	**Endocrine**
☐ Stuffiness	☐ Rectal bleeding	☐ Heat or cold intolerance
☐ Discharge	☐ Constipation	☐ Hot flashes
☐ Itchiness	☐ Diarrhea	☐ Frequent urination
☐ Hay fever	☐ Yellow eyes or skin	☐ Excessive thirst
☐ Nosebleeds	☐ Abdominal Pain	☐ Change in appetite or weight
☐ Sinus pain	**Urinary**	☐ Night sweats
Mouth/Throat	☐ Frequency	☐ Excessive sweating
☐ Bleeding	☐ Urgency	**Other**
☐ Dentures	☐ Burning or pain	☐
☐ Sore tongue	☐ Blood in urine	☐
☐ Dry mouth	☐ Incontinence	☐
☐ Sore throat	☐ Change in urinary strength	☐
☐ Hoarseness	☐ Frequent night time waking to urinate. How often?	☐
☐ Thrush		☐

Please check any of the following health problems that the child currently has, has had in the past, or that family members have had. (Please include parents, siblings, children, aunts/uncles, grandparents)

	Past history? ✓	Current? ✓	Family History? ✓	Relationship to your child?
Anemia	☐	☐	☐	
Asthma	☐	☐	☐	
Cancer	☐	☐	☐	
Chronic Pain	☐	☐	☐	
Diabetes	☐	☐	☐	
Head Injury	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
High Cholesterol	☐	☐	☐	
HIV+	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Liver Disease (including hepatitis)	☐	☐	☐	
Seizures/Epilepsy	☐	☐	☐	
Stomach/GI Problems	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other, Specify:	☐	☐	☐	
Other, Specify:	☐	☐	☐	

EDUCATIONAL HISTORY

Current School: Current grade:
If not enrolled in school please describe reason:

Does your child have ☐IEP ☐504plan ☐Other Please describe why and what is listed in IEP/504:

Describe the child's academic performance in school:

Are there problems going on at school that you are aware of?

Does the child engage in any extra-curricular activities?

SUBSTANCE USE HISTORY

Child's substance used current or past…	First Use?	How Much?	How Often?	Last Use?	Consequences of use? Tolerance, withdrawal, legal or relationship consequences?
Caffeine					
Tobacco					
Alcohol					
Drugs Type:					
Medications not prescribed to them? Type:					

_____ _____

Guardian Signature **Date**

Office Policy Statement

Confidentiality
Information related to your seeking and receiving services will remain confidential. Information will not be disclosed without your written consent. There are a few exceptions:

- When there is reason to believe, you may be in danger of harming either yourself or another person.
- When there is reasonable cause to believe abuse or neglect of a child, elder, or someone with disabilities has occurred.
- When a court order is received.
- For insurance billing purposes.
- When an emergency requires sharing of information.
- Other situations required by law.

Confidentiality and Treatment of Children and Adolescents
Those individuals under the age of 14 and who are not emancipated are required by law to have a parent/guardian consent for treatment. Treatment records may be reviewed by the parent/guardian. Willamette Health & Wellness (WHW) operates under the belief that privacy of patients is of utmost importance and will be maintained except in those instances listed above and for any necessary communication with parent/guardian for treatment planning. Families play a vital role in the recovery process and as such parent/guardian participation in treatment of minors is very important and in most circumstances, is required for effective treatment. Oregon law allows clients 14 years and older to consent to their own mental health treatment by a nurse practitioner but requires the nurse practitioner to involve the parents prior to the ending of treatment except in rare instances.

Children in the Waiting Room
There may be times when you wish to leave a minor child in the waiting room while you are in session with one of our clinicians. Please note that we are unable to provide supervision for children who are unattended in the waiting room. Please note that administrative staff are happy to respond to questions or needs of anyone visiting our offices but they are not able to provide the supervision necessary for a child who requires this. If your child requires supervision you are welcome to bring someone along to attend them. If you have any concerns, please speak to your clinician.

Client Participation/Rights
Treatment will only be effective if the client is engaged and actively involved; this includes family members of children and adolescents seeking treatment. It is important to ask questions about treatment if you are unclear about any aspect of treatment goals or plans. This office is compliant with federal privacy laws and you will be provided with a document outlining your rights under these laws.

Appointments/Cancellation/Missed Appointments
Sessions in this clinic are arranged by appointment only. Appointment times vary in length related to individual needs, clinician recommendation, prearranged treatment plan, and as other treatment factors dictate. An initial evaluation will determine if WHW clinicians are appropriate for your treatment needs. Once this has been established a treatment plan will be developed and will guide follow-up appointments. If one of our clinicians is late we will make up the missed time. If you are late, you may lose that portion of time from your session. If you arrive more than 25% into your allotted period, you may have to reschedule and if so will be charged for a late cancellation fee. Appointments are the responsibility of the patient. If an appointment is cancelled within 24 hours of appointment (telephone message may suffice) a fee of $75 will be charged. If you miss your appointment without a call before appointment time, you will be charged $125. We allow one "no show"/ "late cancellation" without charge. If an appointment is cancelled with more than 24 hour notice no fees will apply. ***Fees for missed or late cancelled appointments are not reimbursable by insurance companies***. If cancelling appointments or no shows become a regular occurrence you may be notified of risk for discontinued treatment.

Telephone Calls and Emergency/Urgent Services

Your provider can be reached during their scheduled business hours. Generally, your non-urgent calls will be returned within two business days. Unless otherwise stated on outgoing voicemail message, we check voicemail at least once per day, more often during business hours and attempt to return all calls within 24 hours of receipt of voicemail. We do not carry 24 hour pagers. During weekend hours and when out of town you will be directed to covering provider(s) who will be assisting with URGENT matters only.

In the case of emergency, call 911 or go to the nearest emergency department. In the event of a crisis in which you need assistance before someone can return your call you may also contact:

- Multnomah County Crisis Line 503-988-4888
- Clackamas County Crisis Line 503-655-8401
- Clark County Crisis Line 360-696-9560
- Washington County Crisis Line: 503-291-9111
- Marion County Crisis Line: 503-585-4949
- Poison Control: 800-222-1222
- Alcohol and Drug Help Line 503-244-1312 or 1-800-923-HELP
- Call to Safety (Domestic Violence crisis line): 1-888-235-5333
- Rape Crisis Center: 503-640-5311
- Cascadia Urgent Walk-in Clinic at 2415 SE 43rd Ave, 7am-10:30pm
- Additional crisis assistance may be found at:
  https://multco.us/mhas/mental-health-crisis-intervention
  http://namimultnomah.org/resources/crisis-services/

If you are hospitalized, please attempt to call your provider within 12 hours or have the hospital call so we can coordinate your care.

Email Communication

We generally do not use email as a form of clinical communication. Treatment assessment and interventions are provided in person and under certain circumstances by phone. There are some situations in which you and/or your provider may decide to use email for communication. Please note that email is not a secure form of communication per HIPAA. Though you may send email to Willamette Health & Wellness at your own risk, we will only be able to reply or initiate clinically appropriate emails if you provide written consent. **Email is not intended for urgent communications.**

Medication Management

All medication has potential to cause side effects as well as interact with other prescription/over-the-counter medications or herbal remedies. However, there is no way of predicting all the potential effects a medication may have on a specific individual. Please be advised that medications used in psychiatry are often prescribed "off-label." This means that such medication may be used to treat/manage symptoms other than those for which it was originally approved by the FDA. This will be discussed during treatment planning. Potential risks, benefits and alternatives will be discussed prior to setting a treatment plan. It is important to update all providers about changes in your medications including prescription, herbal and over-the- counter medications.

Prescription Refills

Prescription refills will be available at your regularly scheduled appointments. Please ensure that you attend appointments to receive them. A prescription refill is not an emergency and requests by phone should be infrequent. Please ***allow one week for refill.***

Fee Schedule

Charges are based on length, complexity, and type of service provided as well as licensure of your provider. You may find the fee schedule for your provider on our website.

Payment
As a courtesy, we bill all insurances. Payment in full (or copay/coinsurance) is due at time of service. We accept checks, cash and major credit cards. Payment of any outstanding balance must be made within 60 days or by other arrangement with Willamette Health & Wellness. Outstanding balances older than 90 days may be subject to a collections agency. Failure to make payments may result in discontinuation of services and/or may be turned over to an outside collection agent.

It is advisable to call your insurance carrier to find out details of your insurance benefits, including pre-authorization if needed. Most plans limit the services for which they will pay. If you request or agree to a service for which your insurance company or its agent later denies payment, then you assume responsibility for paying the entire balance. Insurance companies often request treatment information which would require release of confidential treatment information before payment is made.

Treatment/Length of Treatment
We approach psychiatric/mental health care as a collaborative process. We work with you and, if you desire, your other providers to create a plan for treatment and recovery. If you are ever unclear about the goals you establish with your provider or about any other aspects of your treatment, please ask your provider. Individuals in therapy often are seen weekly or bi-weekly. Medication appointments begin with appointments weekly and/or semi-monthly and after stabilization will decrease in frequency to monthly or every other month or as mutually agreed with your provider. Length of time recommended for use of medication is based on an individual's symptoms and history of symptoms, response to medication and the individual's desire to continue medication. We strongly suggest individuals who are receiving medication should also be in therapy, either with your prescribing provider or another clinician. Discontinuation of treatment may occur when goals have been met, by agreement that another provider may be of better assistance, or when deemed necessary by your provider. Generally, we will discuss ending treatment with you well in advance.

Termination of Treatment
Please let your provider know if you are considering discontinuing treatment. Should you not schedule an appointment for a period of 45 days and make no arrangement with your provider in writing, you may no longer be considered in active treatment. If you "no show" or "late cancel" for two consecutive appointments, "no show"/"late cancel" for one appointment without rescheduling within thirty days, or you are otherwise not engaged in treatment, you will be considered to have terminated treatment. When treatment is terminated for any reason and you wish to re-engage treatment with a provider at Willamette Health &Wellness, we will discuss with you options at that time.

Court Testimony
Please be aware and understand that WHW and our clinicians do not wish to be party to any legal proceedings against current or former patients, or their parents. By entering treatment with us you are agreeing to not involve us in legal/court proceedings or attempt to obtain records for legal/court proceedings when marital or family therapy has been unsuccessful at resolving disputes. Having this expectation reduces the chance that treatment will be misused for legal objectives. If you are involved in, or anticipate being involved in legal or court proceedings, please notify us as soon as possible. It is important for us to understand how, if at all, your involvement in these proceedings might affect our work together. Also, entering treatment for therapy is not the same as a forensic or custody evaluation. If you need such an evaluation, we would be willing to assist you in finding a provider that offers this service.

If we are subpoenaed, we will make every attempt to protect your confidentiality, but as outlined in the Office Policy Statement, be advised that there may be limitations. Please note that we will charge for our testimony, including travel time, wait time, copies of records, and preparation/consultation time. ***We will charge current legal rate as well as expenses incurred in copying and sending records. You will be responsible for these fees as insurance companies will not pay for this.***

Grievance Procedures

If you have a complaint or concern about your treatment, we encourage you to discuss this with your provider so s/he can address your concerns. Willamette Health & Wellness also has a grievance procedure that you should feel free to use. Grievance forms are available upon request. In the event this is not satisfactory you may also speak to your insurance company or contact the Board of your provider.

HIPAA Privacy Notice
Notice of Privacy Practices
Effective Date: September, 2013

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.

What is this Notice? Who will follow this Notice and Why is it Important? As of April, of 2003, a new federal law ("HIPAA") went into effect. This law requires that health care practitioners create a notice of privacy practices for you to read. This notice tells you how Willamette Health & Wellness, LLC will protect your medical information, how this information may be used or disclosed, and describes your rights. If you have any questions about this notice, please contact the Human Resources Coordinator directly at Willamette Health & Wellness, LLC.

Understanding Your Health Information During each appointment, we record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors, your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical or health record, serves as a basis for planning your care and treatment. Typically, we may use your health information and share it to:

- *Treat you and communicate with other professionals who are treating you.*
  For example: Your primary care physician or your psychotherapist might call us to discuss your treatment, and in that situation, we would disclose information about your diagnosis, your medications, and so on.
- *Run our practice, improve your care, and contact you when necessary.*
  For example: Occasionally, we dictate notes from visits, usually for letters to other clinicians. In that case, your health information will be disclosed to the transcriptionist.
- *Bill and get payment from health plans or other entities.*
  For example: To get paid for our services, we have our billing office send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, we fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis. We use an electronic health record which may also include information that identifies you including specific health information.
  We may be allowed or required to use your information in other ways- usually ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.
  For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumer/index.html.

These additional uses and disclosures may include:

- Sharing health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety.
- Using or sharing your information for health research.
- Sharing information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Sharing information about you with organ procurement organizations.
- Sharing information with a coroner, medical examiner, or funeral director when some individual dies.
- Using or sharing health information about you for worker's compensation claims, for law enforcement purposes or with law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.
- Sharing information about you in response to a court or administrative order in response to a subpoena.

Your Health Information Rights

You have the following rights related to your medical record:

- *Obtain a copy of this notice*.
  You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- *Authorization to use your health information*.
  Before I use or disclose your health information, other than as described in this notice, I will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.
- *Access to your health information*.
  You may ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge reasonable, cost-based fee.
- *Change your health information*.
  You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- *Request confidential communications*.
  You may request that when we communicate with you, we do so in a specific way (e.g. at a certain mail address or phone number). We will make every reasonable effort to agree to your request.
- *Accounting of disclosures*.
  You may request a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- *Choose someone to act for you*
  If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- *Ask us to limit what we use or share*.
  You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- *File a complaint if you feel your rights were violated*.
  You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the US Department of Health and Human Services for Civil Rights by sending a letter to 200 Independence Ave, SW, Washington, DC 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Our Responsibilities

- We are required by law to protect the privacy of your health information, to provide this notice about our privacy practices, and to abide by the terms of this notice.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice.
- Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law and as described above, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.
  For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Will We Disclose Your Health Information to Family and Friends? While the new law allows such disclosures without your specific consent (if it contributes to your treatment), our office policy is that we will generally not share your clinical information with your family without a signed authorization from you. The BIG EXCEPTION to this is if I believe you pose an immediate danger to yourself or someone else—in that case, we will do whatever is necessary, even if that means breaching confidentiality.

For More Information or to Report a Problem. If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact us at Willamette Health & Wellness at any time. If you feel your privacy rights have been violated in any way, please let us know and we will take appropriate action.

You may also send a written complaint to:

Department of Health & Human Services, Office of Civil Rights,
Hubert H. Humphrey Building 200 Independence Avenue
S.W. Room 509 HHH Building
Washington, D.C. 20201

Authorizations and Informed Consent

Print Patient name: _____ **Patient date of birth**: _____

Acknowledgement of Office Policies

Initial here _____ I have received, read, understand, and agree to the office policy updates as outlined in the Office Policy Update Statement for Willamette Health & Wellness, LLC (WHW).

Consent for Treatment

Initial here I freely and voluntarily consent to treatment provided by Willamette Health & Wellness, LLC. I understand that I have the right to terminate my participation at any time.

Authorization for Release Information and Assignment of Insurance Benefits

Initial here _____ Willamette Health & Wellness, LLC has my permission to communicate with my insurance company and to provide information necessary for the purposes of obtaining authorization for services, provision of services and coordination of care. Willamette Health & Wellness, LLC has my permission to bill my insurance company and to provide necessary information for the purposes of obtaining authorization for services, benefit information and payment. I understand the professional services rendered are charged to me and, as a courtesy, Willamette Health &Wellness, LLC will bill my insurance company. I authorize Willamette Health & Wellness, LLC to bill my insurance company, and accept payment from that company on my behalf for all services relating to my care. I understand that I am financially responsible for all charges not covered by my insurance and for any appointment that I fail to keep or cancel with less than 24 hours or one business days' notice prior to that appointment time. I acknowledge that any money credited as overpayment due to me will be refunded after completion of treatment upon request.

Use of Email

Initial here _____ I request that WHW use email as a form of communication as deemed necessary and appropriate. I acknowledge that email is an unsecured method of communication.

Billing and Insurance
For billing purposes, I authorize the below the person(s) to discuss insurance and/or payment.

Initial here Print Name: _____ Relationship: _____

Initial here _____ Print Name: _____ Relationship: _____

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My signature below verifies my agreement to all initialed agreements above.

Signature of patient: _____ Date: _____

Signature of patient: _____ Date: _____
(if applicable)

Print Guardian Name: _____ Relationship to patient: _____