Children's Program Registration Packet for New Clients

Please review ***all*** forms contained in this packet ***before*** your first appointment. Complete required forms and either mail them to the clinic or bring them to your appointment. It will take approximately 30-45 minutes to complete all forms.

Please do not email or scan these forms back to us, mail or bring them with you.

If you have been seen for consultation/evaluation/treatment elsewhere in the past please provide records. Complete the Release to Disclose Confidential Information Form.

- **Required forms to be completed:**

✓ Information Form

✓ Consent for Healthcare Operations

✓ Child Development Questionnaire

✓ Consent to Treatment

✓ Privacy Policy Acknowledgement and Consent Form

✓ Release to Disclose Confidential Information Form.
Complete this if you have been seen by another provider. Mail or fax this to the past provider of services.

- **Forms to be read and reviewed:**

✓ General Financial Policy

✓ Privacy Policy

REMEMBER:

- You were notified when scheduling regarding your financial responsibility. If we bill your insurer we will attempt to verify benefits. We collect any deductible/co-payment/co-insurance/full amounts at check-in on the day of your appointment.

- We are now required by Federal Law to request and maintain photo identification of the financially responsible party. Please bring a photo ID with an address (such as a driver's license, passport or other ID). If the ID does not have the address, please provide other evidence of current address.

- **To cancel a scheduled <u>therapy or consultation appointment</u>, please call during office hours and <u>give at least 48 business hours' advance notice</u>. A mandatory fee of up to 100% of the charge will be assessed for missed appointments or appointments cancelled without notice. Cancellations left on voicemail or emailed after business hours will be considered received as of the next business day. Reminder phone calls are not guaranteed.**

- **If you must cancel an <u>evaluation appointment</u>, please notify us <u>at least one week in advance</u>. We may elect not to reschedule evaluations cancelled without sufficient notice.**

PLEASE CALL if you have any questions. Our phone number the (503) 452-8002 or (503) 548-4844. You can find a map and directions to the clinic at our web site: www.childrensprogram.com.

We look forward to seeing you!

The Children's Program

CHILDREN'S PROGRAM INFORMATION FORM

BY PROVIDING THIS INFORMATION, I AUTHORIZE YOU TO GIVE REASONABLE AND PROPER CARE BY TODAY'S STANDARDS

Patient: _____ **Date:** _____
(Last) (First) (Middle)

Birthdate: _____ **Sex** _____**Cell Phone:** _____ **Other Phone:** _____

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Parent #1 _____
(Last) (First) (Middle) (DOB)

Parent #2 _____
(Last) (First) (Middle) (DOB)

Billing Address: _____
(If different) (Street/P.O. Box) (City) (State) (Zip)

E-mail Address: _____
(By furnishing my email address, I consent to the use of email to communicate.)

Referred By (Dr. or Agency) _____

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Patient's Primary Care Physician: _____

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Insurance Company: _____
(Name) (Billing Address)

Subscriber's Name: _____ **Subscriber's DOB:** _____ **Relationship to Client** _____

Identification #: _____ **Group #**: _____

A credit card number must be on file. Charges remaining after 90 days will be charged to avoid further billing or collection fees. The Children's Program will attempt to reach me prior to authorizing the charge.

(please circle) Visa Mastercard Discover American Express

Card# _____**Exp** _____ **Security Code** _____

Signature of Financially Responsible Party **Relationship to Patient** **Date**

Signature of Insurance Subscriber Party (if different from above) **Statement Email Address** **Date**

This form MUST be filled out COMPLETELY and received prior to your first appointment. A health insurance card MUST be presented at the first appointment. Federal Law requires verification of the identity/address of the patient, patient, person responsible for fees, and insurance subscriber. Please be prepared to provide these documentation with a PHOTO ID with an address or alternate documentation of address at check-in.

1/17

CONSENT FOR HEALTHCARE OPERATIONS

CLIENT_____**DOB:**_____

I understand I am financially responsible for all charges. Payment is due in full on the day of service. If the Children's Program agrees to bill insurance, I will pay co-payments, co-insurance or deductibles as required at each visit. Only my primary insurance will be billed. I understand billing insurance is not a guarantee of payment. If my insurance denies coverage for services or procedures, I am responsible for the charges. Accounts must be paid in full within 90 days. Balances remaining after 60 days will accrue billing charges. Charges remaining after 90 days will be charged to the credit card on file to avoid further billing or collection fees.

- I request health insurance payments be made directly to Children's Program. If the insurance carrier sends payment to the patient/family member, I will forward payment to the Children's Program for credit to my account. **The Children's Program may disclose the information necessary to process my insurance claims to any person, corporation, or agency responsible for payment including: ☐ insurance carrier ☐ school ☐ other (specify)**

- I acknowledge that the patient does not hold Oregon Health Plan Insurance (OHP). If the patient unknowingly has OHP insurance, as either primary or secondary insurance, I waive the right to have OHP billed.

- In cases of divorce, the parent/guardian initiating service is responsible for the account and must sign this form. If that parent does not carry the client's health insurance, this form must also be signed by the individual who carries the insurance in order to submit a claim and have the benefits assigned to our office.

- I understand that I must call **DURING OFFICE HOURS** and give at least **48 business hours advance notice** when canceling an appointment. If I fail to do so, I understand I will be charged up to 100% of the appointment fee. Evaluation appointments require a one-week notice. We may elect not to reschedule evaluations cancelled without sufficient notice.

- If I am receiving services under a managed care mental health insurance contract, I understand I may be required to obtain preauthorization before scheduling appointments. The health insurance carrier may limit the number of appointments I can schedule, or the time period in which appointments may occur. My health insurance may limit the types of procedures or diagnoses for which treatment is provided. I agree to be financially responsible for appointments that are not covered by health insurance because of breech of any of these conditions.

- If I choose to submit claims for services outside Children's Program insurance billing policies, I am aware that Children's Program will not accept assignment/provider discounts.

- I understand I must notify the Children's Program of any changes in my health insurance coverage prior to the next appointment. I understand the Children's Program will not retroactively bill for changes if insurance carrier.

- In the event of nonpayment of charges, the Children's Program shall be entitled to disclose information and recover all costs and expenses incurred in seeking collection of such charges including, without limitations, court costs and reasonable attorney's fees, whether such claims are pursued through court proceedings, appellate or bankruptcy proceedings, arbitration, or mediation.

Patient care coordination standards strongly recommend the practice of sharing information with the patient's PRIMARY CARE PROVIDER. I consent to the Children's Program exchanging information as appropriate.

_____

Name of Primary Care Provider (Pediatrician) **Group Affiliation if Applicable**

_____

Office Address

I have read and authorized the above.

_____

Financially Responsible Party/Legal Guardian Date Relationship to client

CHILDREN'S PROGRAM CHILD DEVELOPMENT QUESTIONNAIRE

Please complete and return BEFORE your scheduled appointment. This questionnaire provides historical information to assist us in a thorough evaluation/consultation. We see children of all ages with differing problems, so some questions may be irrelevant to your child, while other information is required by insurance companies for chart review. You may ignore questions that do not apply. This information is confidential and will be released only with a signed release of information to satisfy health insurance requirements, or in situations in which the law requires clinicians to make exceptions to confidentiality. THANK YOU.

Child/Patient's legal name: _____ DOB _____

Gender _____ Age _____ Grade_____ School _____

Person completing form: _____

☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent ☐ Grandparent ☐ Other

Child lives with _____

Referred by (check all that apply): ☐ self ☐ physician ☐ client/friend ☐ school ☐ clinician ☐ insurance

Have you had services at the Children's Program before? ☐ No ☐ Yes

(if yes, describe) _____

CHILD AND FAMILY INFORMATION

1. Parent #1 _____ DOB _____ Relationship to Client/Patient _____

   Address _____
   (street/P.O. Box) (city) (state) (zip)

   Email Address _____

   Cell phone _____ Other Phone _____

   Occupation _____

   Education (highest level completed): ☐ High School ☐ College ☐ Graduate Degree

   ☐ Married ☐ Divorced ☐ Living Together ☐ Other _____

   If divorced, what is the legal custody/arrangement _____

   Parent #2 _____ DOB _____ Relationship to Client/Patient _____

   Address _____
   (street/P.O. Box) (city) (state) (zip)

   Email Address _____

   Cell phone _____ Other Phone _____

   Occupation _____

   Education (highest level completed): ☐ High School ☐ College ☐ Graduate Degree

   ☐ Married ☐ Divorced ☐ Living Together ☐ Other _____

   If divorced, what is the legal custody/arrangement _____

2. Are other adults involved in parenting? ☐ Yes ☐ No

   Name _____ DOB _____

   Relationship to patient _____

   Name _____ DOB _____

   Relationship to patient _____

Today's Date _____

List Children in family, first born to last:

1. Name _____ Age _____
2. Name _____ Age _____
3. Name _____ Age _____

Other people in household:

1. Name _____ Relationship _____
2. Name _____ Relationship _____
3. Name _____ Relationship _____

3. Has this child experienced (please list dates):

_____Family Moves _____Marital separation _____Divorce _____Remarriage _____Other

4. What do you want to address in this consultation?

5.Have you sought treatment for medical/behavioral/educational concerns in the past?

6.Tell us about your FAMILY HISTORY. Include those diagnosed or with significant characteristics.

	Mother	Father	Siblings	Grandparent	Aunt/Uncle	1st Cousins
Inherited/medical conditions						
Language learning disability						
ADD/ADHD						
Anxiety						
Autism Spectrum Disorder						
Sensory sensitivties						
Depression						
Schizophrenia						
Substance/alcohol abuse/addictive behavior						
Bipolar Disorder						
Criminal/legal involvement						
Past treatment for other conditions						

CHILD/PATIENT DEVELOPMENTAL HISTORY & MEDICAL INFORMATION

Name of Patient's physician: _____ Phone _____ Date of last visit _____

Name of Patients's other specialists: _____ Phone _____ Date of last visit _____

Name of Patients's other specialists: _____ Phone _____ Date of last visit _____

Were there problems/concerns with: ☐Pregnancy ☐Labor/ Delivery ☐During newborn period
If yes describe:

Current Medications:

List age developmental milestones were achieved:

Walking _____
Understanding language _____
Speaking single words _____
Speaking, putting two words together _____
Pottying _____

Has this child experienced:

☐ Illness/hospitalization
☐ Surgery
☐ Seizures
☐ Chronic ear infections
☐ Allergies
☐ Weight loss/gain
☐ Injury/trauma to the head
☐ Serious illness
☐ Loss/death
☐ Medical condition we should be aware of
☐ Parents seperation/divorce
☐ Remarriage
☐ Family moves
☐ Illness of family member
☐ Witnessing violence
☐ Physical/sexual abuse

Patient Name _____ DOB _____

Are there concerns about:

- ☐ Diet/eating
- ☐ Sleep: specify # of hours nightly ___
- ☐ Bowel/bladder control
- ☐ Sensory sensitivity
- ☐ Attention
- ☐ Physical complaints
- ☐ Stomach/headaches
- ☐ Tobaco/drug/alcohol use
- ☐ Electronics use
- ☐ Tiredness

SCHOOL HISTORY

Please list schools attended and successes/difficulties, repeated grades, teacher comments and other relevant information.

Level	Name of School	Experience
Preschool		
Grades K-3		
Grades 4 and 5		
Middle School		
High School		

Has your child had evaluations at school? Private clinics/agencies? Please describe:

School/clinic/agency	Date	Explanation

Has your child received special education/remedial services? ☐ Yes ☐ No If yes please explain: _____

_____

_____

_____

Do you have concerns about:

- ☐ Grades
- ☐ School Performance
- ☐ Relationships with teachers
- ☐ Homework
- ☐ Relationships with peers/friends in school
- ☐ School Refusal
- ☐ Suspension/Expulsion

If yes, please describe

Patient Name _____ DOB _____

Have you spoken to or met with:

☐ Child's Teacher ☐ Principal
☐ School Counselor ☐ Other ,specify: _____

What else should we know?

PLEASE ATTACH/BRING COPIES OF PAST EVALUATIONS, RELEVANT SCHOOL INFORMATION, REPORT CARDS, ETC.

---------- For Office Use Only ----------

This information has been reviewed and considered in evaluation and treatment planning.

Clinician's Signature _____ Date _____

Clinician's Signature _____ Date _____

Patient Name _____ DOB _____

TREATMENT CONSENT

WELCOME TO THE CHILDREN'S PROGRAM! We look forward to assisting you with your goals. Here is some important information you should know BEFORE we begin to work with you/your child(ren)/family.

STAFF AND OUR SERVICES: The Children's Program is a private, multidisciplinary clinic. Our clinical staff consists of developmental/behavioral pediatricians, consulting psychiatrists, licensed psychologists, licensed professional counselors, speech/language pathologists, and a certified educational specialist. We help adults, families and children with social, emotional, developmental, and learning concerns. When you call for an initial appointment we encourage you to formulate questions for us to answer or specific goals you want to accomplish. With that information, we will schedule appointments for consultation, evaluation and/or treatment with appropriate staff. Your clinician will suggest the frequency of appointments. Patients may call or schedule return visits while in the office. Treatment is considered concluded if a period of 120 days or greater has passed since the last appointment, unless otherwise specified by you and your clinician. We will attempt to remind you of your appointment via email, text and telephone.

During the first appointment, your clinician will introduce him/herself to you and, at your request, share specifics regarding his/her education and training. You can then further clarify goals and agree how they will be reached. If you have difficulty describing clear goals for treatment, it is important to discuss this with your clinician. We will work with you to meet your/your family's specific needs. It is a collaborative process that is provided without a guarantee of satisfaction or results. You retain the right to request changes in treatment or to end treatment at any time. When medication is recommended, your doctor will discuss the risks, benefits, and alternatives. When accepting a prescription for medication, you agree to follow the prescribing physician's recommendations regarding ALL aspects of treatment. If we recommend referral inside the clinic, information will be shared between clinicians. If we recommend referral outside our clinic, we will attempt to provide you with alternatives.

IF YOU ARE RECEIVING SERVICES UNDER A MANAGED CARE HEALTH INSURANCE CONTRACT, your policy may limit behavioral health coverage to **"medically necessary" procedures (for acute symptom relief)**. It is the responsibility of the patient/ family to ensure all necessary preauthorization is current. Your provider has an agreement with your insurance company to provide services within the limitations of these conditions. The managed care company may require a release of information about your treatment to the primary care physician. Your managed care health insurance company hires reviewers to assess the record keeping and functioning of provider offices. As part of this process, they may either send a reviewer to our office to inspect your record or request a copy of your record be sent to their office for review. If this is the case, we will follow all procedures to protect the confidentiality of your record. Your managed care insurance may request that information regarding treatment and/or treatment authorization be transmitted via facsimile or e-mail. If you do not want us to send or receive information in this manner on your behalf please inform your clinician and specify this request in writing. Some concerns you want to address in therapy may not meet the conditions of your insurance coverage. Should you want to receive treatment for a non-covered condition, your therapist will discuss options with you.

The Children's Program will not be a party to any legal proceedings/lawsuits. Our goal is to support clients to achieve therapy goals, not to address legal issues. Clients entering treatment agree not to involve the Children's Program and their treating clinician in legal/court proceedings or attempts to obtain records of treatment/evaluation for use in legal/court proceedings.

CONFIDENTIALITY: The privacy of your evaluation/treatment is important to us. Information shared with clinicians is confidential. The Children's Program maintains a single chart to record the services that are provided. We will maintain your chart for 7 years from the last date of treatment. Information from that record can be shared with other professionals/agencies/individuals **ONLY** with your **WRITTEN** consent by signing a release to disclose confidential information. Please be conservative and circumspect when requesting release of information. This is to protect your child/family's privacy now and into the future as your child ages. Please be aware that the record we release may be released by other providers/agencies. The Release to Disclose Confidential Information form requires specifying **WHAT** information is to be shared, **WHO** shall receive it, for **WHAT** purpose and the **DATES** of the confidential information. In Oregon, the age of consent for treatment and release of mental health records is 14 years of age. The signature of patients 14 years or older is required to release the information in the treatment record. With written permission, we can communicate with other professionals on your behalf via phone or email and provide evaluation reports and/or a summary of treatment. We do not generally release patient chart notes or test protocols. If under a special circumstance, release of additional information is requested, this will be reviewed after conferring with the patient/family members and the requesting clinician/physician. There may be charges for photocopying and mailing records. In the case of divorce, both parents have equal access to the information in the chart of a child under the age of 14. If consultation with other professionals on your behalf is necessary, your anonymity will be preserved.

We may, but do not guarantee calls to remind you of upcoming appointments. Please let us know **EACH** time you schedule an appointment if you **DO NOT** want a reminder call.

We respect the rights of a child/parent/adult to have particular information remain private between themselves and the therapist. If you have concerns about this, let your therapist know and a comfortable arrangement can be reached which allows therapy to progress, yet respects the rights of individuals. Please advise us in writing if you wish to be contacted only in a particular way or only at particular phone numbers. There are several situations in which the law requires clinicians to make exceptions to the confidentiality of communications between client and clinician. These situations are:

- when there is suspected child, elder, or disabled abuse
- when there is threat of harm to self or others
- when medically relevant information is needed for emergency medical treatment
- when records are subpoenaed by order of a Judge, or if the client waives confidentiality
- when conducted at the request of an outside agency with the client's approval

Information may be required by your insurance company to process a claim. Typically, this involves disclosure of a diagnosis and the dates of services, though at times, more may be required. Your file may be reviewed for quality assurance by the Children's Program or your insurance company. We will maintain your confidentiality during this process.

ELECTRONIC COMMUNICATION, I.E., E-MAIL/FAX, PRESENTS A POTENTIAL RISK TO PATIENT CONFIDENTIALITY. Email is not a replacement for office visits. While families and patients may find this a convenient way to communicate they must be aware of the risks and discuss them with their clinician. If a patient/family still wishes to assume these risks and communicate with their clinician in this way, they may acknowledge this by signing below and exchanging information with their clinician within a session. Clinically relevant information exchanged by fax/email may become a part of the clinical record.

FEES/PAYMENT: Fees are billed on an hourly basis and vary for each discipline. When you call for an appointment, we provide an estimate of the fee(s). We will inform you if this changes. We request payment of the fee(s) at each appointment. In some cases, we will bill your primary insurance directly. HOWEVER, THIS DOES NOT GUARANTEE COVERAGE. Health insurance plans vary widely in their mental health coverage. A copy of our **FINANCIAL POLICY** is available on our website. **Please read our Financial Policy**. We require that you read/sign **INFORMATION** and **CONSENT FOR PAYMENT** forms prior to initiating evaluation/treatment**.** We require you provide a valid credit card number. Charges remaining after 90 days may be charged if you have not called us regarding arrangements for payment of a past due balance

There are circumstances that impose additional fees. To cancel a scheduled therapy appointment, please call during office hours and give at least 48 business hours' advance notice. To cancel an evaluation appointment, please notify us at least one week in advance. We may elect not to reschedule evaluations cancelled without sufficient notice. A mandatory fee of up to 100% of the charge may be assessed for missed appointments or appointments cancelled without sufficient notice. Cancellations left on voicemail after business hours will be considered received as of the next business day. Reminder phone calls are not guaranteed. You will be charged for telephone/email consultation outside a session or a cancellation without sufficient notice. This is billed at the clinician's hourly rate and is not reimbursable by a health insurance company. Same day requests for refills of prescriptions incur a $10 charge. If a clinician is required to testify on a client's behalf court preparation/travel/testimony will be billed at $200 per hour. In the unlikely event that your account is referred to a collection agency or small claims court, we will release your name, address, phone number, social security number, and amount owed. You will be notified in writing if this is to occur.

EMERGENCIES: Office phones are answered between 8:00 a.m. and Noon and 1:00-5:15 p.m. Monday through Thursdays and between 8:00 a.m. – Noon and 1:00-3:30 p.m. on Fridays. The office is closed on Fridays during July and August. Messages may be left on the voicemail at any time. Our clinicians will attempt to return your call within 24 hours. If you feel you have an **emergency** situation that cannot wait until the office re-opens, please call the Answering Service at (503) 294-1309. They will make every effort to contact your clinician; however, it is possible that your clinician may be unavailable or unreachable. Families needing immediate attention are advised to contact the Emergency Room of the nearest hospital.

GRIEVANCE PROCEDURE: If you have concerns regarding these policies, please discuss them with your clinician during your initial session. Should you feel dissatisfied with your treatment for any reason, please talk to your clinician. If you and your clinician are unable to resolve the problems, you may submit a written letter of concern to our Clinic Administrator. You will receive notice of action taken within 10 working days.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND I CONSENT TO TREATMENT. BY FURNISHING MY EMAIL ADDRESS, I CONSENT TO THE USE OF EMAIL TO COMMUNICATE.

Email Address: _____

_____ _____
(Name of Patient) (Date of Birth)

_____ _____
Signature (clients age 14 years and above) (Date)

_____ _____
Signature (Parent/Guardian/Legal Rep.) (Relationship to Client) (Date)
(If Guardian/Legal representative, please provide documentation of guardianship status.)

_____ _____
Clinician's Signature (Date)

Please sign and return this form.

ACKNOWLEDGEMENT AND CONSENT REGARDING PRIVACY PRACTICES

I understand that the Children's Program holds health information about me. I understand that my health information may include information both created and received by the practice/facility, may be in the form of written or electronic records or spoken words, and may include information about my mental health/health history, mental health/health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of mental health/health-related information.

I understand and agree that the Children's Program may use and disclose my mental health/health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other mental health/health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my mental health/health care.
- Perform various office, administrative and business functions that support my practitioner/provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective mental health/health care.

I also understand that I have the right to request and review a description of how the Children's Program will handle mental health/health information about me. This description is known as a Notice of Privacy Practices describes the uses and disclosures of mental health/health information made and the information practices followed by the employees, staff, and other office personnel of the Children's Program, as well as my rights regarding my mental health/health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a written copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of the Children's Program's Notice of Privacy Practices in effect is available in written form upon request and is posted on the website at www.childrensprogram.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that the Children's Program is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I reviewed the Notice of Privacy Practices online or in written form.

Patient's Name: _____ Date of Birth: _____
please print

By: _____ Date: _____
(Signature of Patient – age 14 years or older)

By: _____ Date: _____
(Signature of Patient's Representative)

Description of Representative: _____
(parent/guardian/legal representative)

RELEASE TO DISCLOSE CONFIDENTIAL INFORMATION

Regarding: _____ _____
Client/Patient Name Date of Birth

I authorize the Children's Program, 6443 SW Beaverton-Hillsdale Hwy, Suite 300, Portland, OR 97212
(503) 452-8002

☐ to exchange information with ☐ to receive information from ☐ to provide information to

☐ by mail ☐ by E-mail ☐ by Fax ☐ by telephone

_____
Name

_____
Mailing Address (must be complete to be processed)

_____ _____ _____
E-mail Address Telephone Fax number

For the purpose of: ☐ Treatment Planning ☐ Coordination of Care ☐ Diagnostic Evaluation
☐ Other (please specify): _____

YOU MUST BE SPECIFIC regarding the information you are requesting:

- ☐ Telephone Consultation between the Children's Program and _____
- ☐ Email Contact between the Children's Program and _____
- ☐ Developmental Pediatric Report Dated: _____
- ☐ Psychological Report Dated: _____
- ☐ Psychological Treatment Summary
- ☐ Educational Report Dated: _____

(Please see the Confidentiality section of your Treatment Consent form regarding the release of chart notes.)

This authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose. You have the right to revoke this Authorization at any time in writing to your clinician or our clinic administrator. Identify the date you signed the Authorization, the recipient of the information identified, and state that you are revoking the Authorization. We cannot take back uses or reverse disclosures already made with your permission.

I have reviewed and I understand this Authorization. By signing this, I understand that I am directing you to disclose information to /receive information from a person or organization that may not have or obey the same obligations to protect privacy under state and federal law. The disclosure of the information specified above carries with it the potential of an unauthorized re-disclosure and loss of protection under state and federal law.

Communication by electronic, audio or video means, i.e. Fax, E-mail or Skype is not secure and presents a significant risk to patient confidentiality. By requesting exchange of information or communication by electronic means I acknowledge that I am aware of these significant additional risks to confidentiality and agree to assume these risks and know that confidentiality, review, re-disclosure, dissemination, distribution or copying of this information cannot be guaranteed.

_____ _____
Clients (ages 14 or older) Date

_____ _____
Signature for client/parent/guardian (for clients younger than 14) Date

THERE MAY BE A CHARGE TO PROVIDE RECORDS. REQUESTS FOR A CHART IN ENTIRETY WILL INCUR A MINIMUM CHARGE OF $25. A CREDIT CARD NUMBER MUST ACCOMPANY THIS REQUEST.
☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **AMX Name of Cardholder:**

CC# _____ **Exp. Date**_____ **CCV** _____ **Zip Code** _____

Financial Policy

We want billing arrangements to be as straightforward as possible.

1) Services provided by the Children's Program are billed on an hourly basis. Charges are submitted under the client's name. If a child is the client, billing is submitted under the child's name.

2) **Medical and Psychological services** provided at the Children's Program may be covered under the **mental health benefits** of your health insurance contract. Extended phone calls, follow-up correspondence, and out-of-the office consultation cannot be billed to health insurance. **Educational services are not covered.** We do not submit claims for these visits.

3) Our office maintains a direct billing relationship with many, but not all, health insurance companies**. It is important for families to educate themselves about the mental health benefits of their health insurance policies.** Determine if your company provides a managed mental health benefit, whether you must meet a deductible, the amount of your co-payment/coinsurance, and whether pre-authorization is required. In most cases pre-authorization is initiated by the family/patient and NOT the primary care physician/pediatrician. Coverage may NOT be available for specific diagnoses e.g. Attention Deficit, Autism Spectrum, or for particular services, e.g., psychological testing, family therapy.

4) We will do our best to inform you of your financial obligation when scheduling your appointment. When a child is the client, the parent/guardian seeking services is responsible for the account. An **Information** form and a **Consent for Payment and Healthcare Operations** form must be completed prior to your first appointment.

a) If we are NOT contracted to bill your health insurance, **payment in full** is due at the time of the appointment. Families using an out-of-network benefit can request copies of fee slips and a guide for self-billing insurance.

b) If we are billing your primary health insurance company. We require a current credit card number remain on file. We will attempt to gather information about your mental health benefits. However, this information does not guarantee payment. We collect payment to **meet your deductible**, if applicable, and **co-payments/coinsurance amounts** on the day of your appointment. The agreement with your insurance carrier is a contract between you, your insurance company and, in some cases, your employer. Please remember, billing insurance is not a guarantee of payment. If your insurance plan does not cover a service, a procedure, or a diagnosis, you are responsible for these charges.

Financial arrangements between divorced parents must be handled independently of the Children's Program. In cases of divorce, the parent seeking service is responsible for the account and must sign the Consent for Payment and Healthcare Operations form. If the other parent holds the insurance, they, too, must sign a Consent for Payment and Healthcare Operations form. This gives us permission to bill the health insurance. Fees due on the day of an appointment must be collected at every visit regardless of who brings a child to the appointment.

5) We will bill a patient's primary insurance carrier if we are provided current and correct information. Our policy is to allow insurance carriers 60 days to pay a claim. **Accounts unpaid after 60 days will be assessed a re-billing charge. If a payment has not been received from an insurance company within 60 days, we encourage the patient to work actively with the insurance company to secure payment.** Please notify us prior to your next appointment if you have a change in insurance.

6) **Accounts with unpaid balances after 90 days will be referred for collection action. To avoid collection action and re-billing charges you will be asked to provide a credit card number. This will be kept on file and can be used to settle the balance.** We make every attempt to contact you prior to charging an unpaid balance.

7) Payment can be made with a check, cash, or credit card. Please make checks payable to the Children's Program. While we accept your HSA, HRA or Benefits credit card, we cannot guarantee that they will process. Please call ahead to make a payment arrangement for teenagers coming on their own. Please call our Billing Office at (503) 452-8002 (Option 3 for billing) if you need a printout of your account or to answer any questions.

8) In the event of non-payment of charges, the Children's Program shall be entitled to recover all costs and expenses incurred in seeking collection of such charges, including, without limitation, court costs and reasonable attorney's fees, whether such claims are pursued through court proceedings, appellate or bankruptcy proceedings, arbitration, and/or mediation.

9) **Please note our cancellation policies outlined below.**

a) **If you must cancel an <u>evaluation appointment</u>, please notify us <u>at least one week in advance</u>. We may elect not to reschedule evaluations cancelled without sufficient notice.**

b) **To cancel a scheduled <u>therapy appointment</u>, please call during office hours and <u>give at least 48 business hours advance notice</u>. A mandatory fee of up to 100% of the charge will be assessed for missed appointments or appointments cancelled without this notice. Cancellations left on voicemail after business hours will be considered received as of the next business day. Reminder phone calls are not guaranteed.**

CHILDREN'S PROGRAM PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. 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 main upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.* Different personnel in our office may share information about you and disclosure information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, or scheduling lab work or consultations. Family members and other mental health/healthcare providers may be part of your clinical care outside this office and may require information about you that we have.

Federal and State law require your written consent to release mental health/health information. The Consent will specify who is to receive the information, the purpose of the release of information, and a time period after which the Consent will terminate. You may modify or revoke a Consent at any time. If we are unable to fulfill our requirements related to treatment, payment or mental health/healthcare operations, we may choose to discontinue providing you with mental health/healthcare treatment and services. In some instances, we may need specific, written authorization from you in order to disclose certain types of specifically protected information such as HIV, substance abuse and genetic testing information.

For Business 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 or employee review activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., information technology services, provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available 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, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the Health Department)

- Required by Court Order
- 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.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services 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 explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

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 Clinic Coordinator:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about services provided.
- **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.
- **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 services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g., telephone, email, postal mail, etc)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your email address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal email address simply because you visit our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Clinic Coordinator at (Children's Program). If you have questions and would like additional information, you may contact us at (503) 452-8002 ext. 121.