☐ **Phillip Snell, D.C.** Chiropractic Physician
☐ **Scott Haines, D.C.** Chiropractic Physician
☐ **Kelly Owens, N.D.** Naturopathic Physician
☐ **Taya Lindley, L.Ac.** Licensed Acupuncturist
☐ **Al Downs, L.Ac.** Licensed Acupuncturist
☐ **Eva Hosseinion, L.Ac.** Licensed Acupuncturist
☐ **Aimee Perkins, LMT** Therapeutic Massage
☐ **Sara Armstrong, LMT** Therapeutic Massage
☐ **Sheri Blue, LCSW, CADC I, LMT** Counseling, Therapeutic Massage

Hawthorne Wellness Center

3942 SE Hawthorne Blvd. • Portland, OR 97214 • (503) 235-5484

The following information is needed for our files so we can better serve you as a patient. Please fill in ALL portions of the form. PLEASE PRINT CLEARLY. Thank you.

Patient Information

Patient's Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ E-MAIL: _____

Employer: _____ Work #: _____ Occupation: _____

Age: _____ Date of Birth: _____ Gender: _____ Marital Status (Circle One): S P M D W

Number of Children & Ages: _____ If patient is a minor, parent/guardian: _____

Referred to this clinic by: _____ Is this visit due to an accident?_____

Auto _____ Work _____ Home _____

Emergency Contact Information

Name: _____ Relationship: _____Phone:_____

I give my consent for Hawthorne Wellness Center to contact the above named person in case of an emergency.

Signature: _____ Date: _____

Insurance Information

Primary Insurance Company Name: _____ Phone # (back of card): _____

Policy/ID #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

Appointment Reminders

Please circle one of the following options: Voice Message E-Mail Text Message No Reminder

INSURANCE RECORDS RELEASE AND PAYMENT AGREEMENT

I authorize my insurance company to make payment directly to this clinic for services rendered and permit this clinic to endorse co-issued remittances for the conveyance of credit to my account. **I understand this clinic will prepare any medical records, necessary forms and reports to assist me in making collection from my insurance company and that any amount paid directly to this clinic will be credited to my account upon receipt.** However, I clearly understand and agree that all services rendered are charged to me directly and that I am ultimately personally responsible for full payment. I agree to pay any costs or fees incurred in connection with the collection of my account, including attorney fees and court costs.

Signature: _____ Printed Name: _____ Date: _____

THIS PATIENT IS A MINOR. PERMISSION IS HEREBY GIVEN BY ME TO THE PROVIDERS OF THIS CLINIC TO EXAMINE AND TREAT THE PATIENT.

Signature: _____ Printed Name: _____ Date: _____

Sheri Blue, LCSW, CADC I, LMT #5842
Hawthorne Wellness Center • 3942 SE Hawthorne Blvd, Portland, OR 97214 • (503) 235-5484

Name: _____ Date:_____

What are the concerns that you are seeking help for today? What made you decide to seek help now? What do you hope to gain from our work together?

How long have these issues been present?

Have there been any recent stressors in the last 6 months (loss, relocation, divorce, financial strain, physical illness)?

Please give any mental health history (previous work with counselor, therapist, psychiatrist, hospitalization).

Do you have a history of experiencing any form of abuse (Physical, Sexual, Emotional, Neglect or Domestic Violence)?

Have you ever attempted to seriously harm yourself or anyone else at any time in the past?

Please provide any significant medical history (such as illnesses, accidents, head trauma, etc). How would you describe your health? Do you eat well? Sleep well?

Are you taking any medications? If yes, please list name, dosage and condition being treated, and prescriber name.

Are there specific changes you know you'd like to make in your life? Is there anything that has stood in the way of making those changes?

Any substance abuse, past or present, for yourself or household member?

Who lives with you?

Name	Age	Relationship to you

How is your environment supportive or not supportive of you? Who in your environment is supportive or not supportive of you?

What are your hobbies, interests, and activities?

Sheri Blue, LCSW, CADC I, LMT #5842
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Office Policies and General Information Agreement for Counseling and Psychotherapy Services

Confidentiality

Your participation in treatment and all information about you is considered confidential and cannot be disclosed without your written consent except where disclosure is required by law. Some of those exceptions to confidentiality include: (1) when I suspect a child or elder is being abused or neglected; (2) when I believe you present a clear and imminent danger to yourself or a threat to others; (3) when a court subpoenas me to testify or subpoenas my records; or (4) when an insurance company that is helping to pay the fee requires information about your diagnosis and/or reports about your treatment. The Notice of Privacy Practices that you received outlines the additional legal exceptions to confidentiality that apply to my practice. Please feel free to discuss with me any questions or concerns about confidentiality at any time.

The Counseling/Therapy Process

Counseling is an active partnership between the client and the therapist. Please feel free to ask questions about our process together. Many people have experienced relief from their primary concerns through therapy. However, there are important risks to consider as well. Therapy can result in an increase of uncomfortable feelings and emotional states such as worry, sadness, confusion, anger or fear. Making changes in your own beliefs and behaviors can also have an impact on your social, family and work relationships. There is no guarantee that therapy will produce positive or intended results. If you feel you are not getting the most out of your time, please tell me so that we can discuss your needs and make changes. If I feel I am unable to properly address your treatment concerns, I will offer you referrals to appropriate practitioners.

Messages and Telephone Contact

If you would like to cancel or reschedule your appointment, please call the front desk at (503) 235-5484. If you would like to communicate with me directly, you may email, text, or call me at (503) 610-6837. I check my messages several times during the workday, and respond within 24 hours with the exception of weekends and holidays. Please be aware that e-mail and text messaging are unencrypted and therefore subject to possible privacy breaches that are beyond our control. If you need immediate support while waiting for a return call or are having a mental health emergency, please call the Multnomah County Crisis Line at (503) 988-4888 or go to the nearest emergency room.

Insurance

Accessing insurance coverage requires that you have a diagnosable psychiatric condition and that your symptoms constitute medically necessary treatment in order to resolve. We can discuss your diagnosis, and if it is something you are comfortable having on your health record. I am happy to bill your insurance for you, but you are ultimately responsible for the bill if they decline payment. Please let me know if you have questions about this process.

Consent for Treatment

Your signature indicates that you consent to counseling services with Sheri Blue, LCSW, CADC I, LMT (#5842) and that you understand and agree to comply with the contract terms. You have the right to end services at any time.

Client Signature Printed Name Date

Notice of Privacy Practices

Your additional signature here indicates that you have received a copy of the Notice of Privacy Practices.

Client Signature Printed Name Date

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FINANCIAL POLICY AND AGREEMENT

SELF-PAY

☐ Payment is expected at the time services are rendered. Cash, Checks and Credit Cards (excluding AmericanExpress) are accepted for payment.

PRIVATE INSURANCE

☐ If you have insurance, which covers alternative care or mental health, we will bill your insurance company directly. If you have a deductible, payment is expected at the time services are rendered. Once your deductible is met, your co-payment is due at the time of the office visit. In the event the insurance check is sent to you, you are expected to bring the check to our office to be applied to your account. VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT BY YOUR INSURANCE COMPANY. ANY SERVICES NOT COVERED BY YOUR PLAN IS YOUR RESPONSIBILITY. Visa and MasterCard are accepted for payment.

AUTO INSURANCE

☐ You must notify YOUR insurance carrier of the accident and file a Personal Injury Protection (PIP) form with them. We will bill your auto insurance company. In the event the auto insurance check is sent to you, you are expected to bring the check to our office to be applied to your account. If for any reason your claim is denied or not paid in full by your insurance company, you will be responsible for your bill.

WORKERS' COMPENSATION

☐ You must report your injury to your employer and fill out an injury report form (801) at your place of employment. We will bill your Workers' Compensation carrier. If for any reason your claim is denied or not paid in full, you will be responsible for your bill.

A BOOKKEEPING DISCOUNT IS OFFERED TO PATIENTS WHO PAY THEIR ACCOUNT IN FULL AT THE TIME OF SERVICE, MAINTAIN A ZERO BALANCE, AND DO NOT REQUIRE INSURANCE BILLING BY THIS OFFICE.

I have read and understand the above financial policy that applies to me and agree to abide by the above financial policy.

Signature: _____ Date: _____

IMPORTANT NOTE:

A 24 HOUR NOTICE IS REQUIRED FOR CANCELLATIONS. IF YOU DO NOT GIVE 24 HOURS NOTICE, YOU WILL BE CHARGED A $60 MISSED APPOINTMENT FEE.

I have read and understand the above financial policy that applies to me and agree to abide by the above policy.

Signature: _____ Date: _____

NOTICE OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW CAREFULLY.

Protected Health Information ("PHI") is information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care service. This Notice describes how I may use and disclose your PHI in accordance with applicable law and the *National Association of Social Workers Code of Ethics*.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the terms of the Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. Upon request I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail or providing one to you at your next appointment.

Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations. It is my practice to adhere to stringent privacy requirements for disclosures without an authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked by you in writing at any time.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed for the purpose of providing, coordinating, or managing your health care treatment and related services. This may include consultation with clinical supervisors. I may disclose PHI to any other consultant only with your authorization. I may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related services and resources that we have discussed. Please be aware that e-mail and texting communications are unencrypted and cannot be considered confidential and private. For this reason, e-mail and texting is limited to appointment scheduling unless you have requested otherwise.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, providing diagnosis information, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Required by Law. Under the law, I must disclose your PHI to you upon your request. In addition, I 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.

The following is a list of the categories of uses and disclosures legally permitted without an authorization:

Child Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

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

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

Medical Emergencies. I may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm.

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

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena

(with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

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

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

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious, foreseeable, 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.

YOUR RIGHTS REGARDING YOUR PHI

To exercise any of these rights, please submit your request in writing.

Right of Access to Inspect and Copy. You have the right, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request, you have the right to file a statement of disagreement. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact me if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. Please notify me if you have special requests about how I may contact you.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. There will be no retaliation against you **for filing a complaint.**

The effective date of this Notice is September 2013.