New Priorities Family Services
1655 SW Highland Avenue, #3 Redmond, Oregon 97756
Ph: 541) 923-2654 Fax: (541) 548-8099

INDIVIDUAL INFORMATION FORM

Individual Information

Date: ______________ Individual's Name: ______________________________ Email: ________________

Address: ____ City/Zip: ________________________________

Home: ______________________________ Cell: _________________________ Work: ________________

Birth Date: _________________ Age: ________ Sex: ______________ Social Security Number: ________________

Employer: ___________________________________ Occupation: ______________________________________

Emergency Contact: Name: __________________________ Relationship: _______ Telephone: ________________

City/Zip: ____

Marital Status: Married___ Widowed___ Divorced ___ Single___ **Military Status**: Served___ Serving___ None___

Referred By: _______ Qwest Directory _______ Valley Directory ________ Therapist _______ Friend ______ other____

Responsible Party/Parent/Legal Guardian/Primary Care Giver:

Name: ________________________ Birth Date: __________ Sex: ___ Social Security Number _________________

Employer: _____________________ Occupation: ______________ Work#: ______________ Cell: ____________

Address: ________________________________ City/ Zip _________________ Home#: _____________________

Spouse/ Significant Other Information

Name: __________________________ Birth Date: ____________ Sex: _____ Social Security # __________________

Employer: ______________________ Occupation: ___________ Work # _____________ Home/Cell# ___________

Family Physician: ____________________ Location _____________________ Phone # ____________________

Family Dentist: _____________________ Location _____________________ Phone# ____________________

Insurance Information

Health Insurance Plan: ________________________________ Policy Holder: _____________________________

ID#: ________________ If required by insurance, have sessions been Authorized/Pre-notified-Done Y or N

EAP/Secondary Insurance Plan: _________________________ Policy Holder: _____________________________

ID#: ____________________________ Authorization/Certification#: ____________________________________

I authorize New Priorities Family Services to provide information to my insurance carrier, including diagnosis, services rendered, and progress, as needed to process my insurance claim. I also authorize payment of mental health therapy/counseling benefits to New Priorities Family Services for services provided.

____

Signed (Insured or Authorized Person) **DATE**

NEWP PRIORITIES FAMILY SERVICES
1655 SW Highland Avenue, Suite 3, Redmond, Oregon 97756
info@newpriorities.com

Confidential Personal Data Intake Form

Date: ______________Name: ______________________________Birth Date: ___________Age: _____

Major issue you want to discuss: ____

In your own words, list your strong points:____
____

In your own words, list your weaknesses: ____
____

What is your goal for counseling/What are you willing to do to obtain this goal? ________________________
____

Please make any comments that you feel are important to this counseling process: _____________________
____

Problem Check List:

Never	Sometime/Often		Never	Sometimes/Often	
___	____	Loss of Appetite	___	____	Eat too much
___	___	Poor sleep/sleep too much	___	____	Nightmares
___	___	Not performing in school or work	___	___	Not doing household chores
___	___	Work too hard/over ambitious	___	___	Can't make friends
___	___	Feel people are down on me	___	___	Shy with people
___	___	Unable to have a good time	___	___	Feel rejected
___	___	Communication problems/spouse	___	___	Communication problems/child
___	___	Sex problems	___	___	Financial problems
___	___	Feel depressed	___	___	Feel inferior to others
___	___	Emotions /feelings are numb	___	___	Lack self-confidence
___	___	Worry a lot	___	___	Can't make decisions
___	___	Don't enjoy any activities	___	___	Forgetfulness
___	___	Lack of goals	___	___	Unable to cope
___	___	Afraid of being on own	___	___	Suicidal thoughts
___	___	Feel tense/anxious	___	___	Feel angry/physically
___	___	Unable to be intimate	___	___	Crying spells
___	___	Other: ____			

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OHP Therapy Attendance Policy

In order for us to ensure the best possible results from therapy, you must actively participate in the program developed for you by attending all scheduled sessions.

Appointment Cancellation

We realize there may be circumstances that require you to change your scheduled appointment. When these situations occur, please notify your therapist 24 hours prior to your scheduled appointment change so we may accommodate others waiting for therapy.

Appointment No Show

Our therapists have set aside a specific time to provide your therapy. When you do not call to cancel or do not show for your appointment, this is time the therapist could be providing therapy to someone else. We realize that emergencies do occur, please call right away to make arrangements with your therapist.

Repeated Cancellations or No Shows

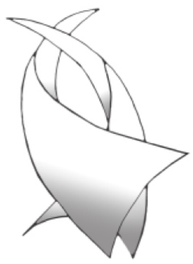
Cancellations or no shows will be documented in your chart. After 3 cancellations and/or 2 no shows we will conclude your services. This shows the therapist, agency, and insurance company this may not be the right time for you to engage in therapy.

Acknowledgement

I have read the attendance policy and acknowledge my understanding of active participation is scheduled therapy sessions.

____Date________________________________
Client

____Date_________________________________
Therapist



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NO SHOW PAYMENT AGREEMENT

I, ________________________ agree to pay $40.00 for any individual session, group, or other treatment activity that I or my son/daughter has agreed to attend and miss without giving notice, unless a crisis occurs beyond your control. We very much understand unforeseen circumstances arise. If you call and staff is unable to take your call, leaving a message is satisfactory.

This agreement does not apply to individuals on OHP insurance coverage; however, failure to contact our office resulting in an unexcused absence may initiate an extended program completion date, a change in the level of care or possible termination of services.

____ ___________
Signature of Individual Date

____ ___________
Signature of Legal Guardian Date

____ ___________
NPFS Counselor (Name / Credentials) Date

____ ___________
NPFS Director, Karen Ludwig MS,NCC,MAC, LPC Date

NEW PRIORITIES FAMILY SERVICES

1655 SW HIGHLAND AVENUE, SUITE 3, REDMOND, OREGON 97756

(541)923-2654 Fax (541)504-7017 www.mynewpriorities.com

Contract for Psychotherapy Services

Cost of Services Provided :

Mental Health		Chemical Dependency	
Initial Evaluation/Consultation	$160	Alcohol/Drug Assessment	$175
Individual Therapy	**75-145**	Individual Session	100
Family Therapy	**140**	Family therapy	140
Group Therapy	**45**	Group Therapy	45

OHP Individuals-Cost of services set by State.

Full payment or your co pay is expected at the time of service. Payment plans to be arranged. Sliding fees or co-pay assistance may be available,discuss circumstances with your counselor. Currently we can only accept cash or check, Visa or Mastercard at our office, be aware that there will be a charge of $20 for checks returned due to insufficient funds. You may also pay using your Credit/Debit Card via PayPal on our website- www.mynewpriorities.com - under the pay for services section. If you have any questions, please check with us prior to your session.

Insurance: As a courtesy, we submit an insurance claim to your insurance company for reimbursement. Please make sure you understand your policy and the services it provides & covers. Many insurance companies/plans require pre-authorization for services; you are responsible for contacting your insurance to ensure services will be covered and provide us with any necessary authorization/certification numbers, expiration dates, or visit limits given to you by insurance. If your insurance does not pay your bill for any reason you will be financially responsible.

Authorization Number ______________________ My Co-pay is$ ____________ Deductible Met? Y/N
Number of Sessions Authorized________ Authorization Period/Expiration Date ______/______/______

Appointments: Your appointment time is a commitment between you and our center to provide you the services needed. This time space is **YOURS.** Therefore, we ask that you give **24-hour notice** of cancellation. We realize that emergencies do occur, please call right away to make arrangements with your therapist or you will be charged a late cancellation fee of $40. You will be charged the $40.00 amount if you are a no call/no show (OHP exempt).

By law, all information obtained in the course of psychotherapy shall remain confidential, and will not be released without your written consent, except under the following conditions:

a. Reporting suspected child abuse
b. Reporting imminent danger to client or others
c. You request my appearance in court to testify on your behalf
d. License consultation or supervision
e. Defense of claims brought by client against licensee
f. If the client is a minor, legal guardian may have a right to information

I have read and understood the contract obligation stated above.

Client Name(print)____Date:____________

Client Signature: ______________________________ under 18, Guardian's Signature: ______________________________

Grievance Policy and Procedure.

NPFS staff will encourage and facilitate resolution of the grievance at the lowest possible level:

To file a grievance an individual is to follow procedures as listed in steps below:

- Initiate a frank discussion between themselves and their clinician regarding individual concerns.
- A grievance shall be put in writing and inserted in the individual's file.
- If issue cannot be resolved the grievance is given to the NPFS Director/Supervisor who "will take action" within 72 hours.
- An investigation of any grievance "will be completed" within 30 calendar days. During this time, the NPFS directors will receive and process the grievance and document any action taken on a substantiated grievance and document receipt, investigation and action taken in response to the grievance.

Expedited Grievances: In circumstances where the matter of the grievance is likely to cause harm to the individual before grievance procedures are completed, the individual or guardian of the individual may request an expedited review. The program director must review and respond in writing to the grievance within 48 hours of receipt of grievance. The written response must include information about the appeal process.

In an individual does not feel NPFS is handling the grievance, the following agencies may be contacted:

*Pacific Source Grievance and Appeals 1-888-863-3637

*Deschutes County Health Services 541-322-7400

*Secretary of the Dept. of Health & Human Services Office for Civil Rights
US Dept. of Health & Human Services
2201 6th. Ave. Seattle, WA 98121-1831

GRIEVANCE APPEALS

Individuals and legal guardians, have the right to appeal, entry, transfer, and grievance decisions if they are not satisfied with the decision within ten working days of the date of New Priorities Family Service's response to the grievance or notification of denial for services. The appeal must be submitted to the CMHP Director in the county where the provider is located or to the Division as applicable.

The CMHP Director or Division must provide a written response within ten working days of the receipt of the appeal. If the individual or guardian is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten days of the date of the written response to the Director.

I have reviewed and received a copy of this document:

Client (print) ______________________ *Signature:* ______________________ *Date:* ______________

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Acknowledgement of Receipt of Notice of Privacy Practices

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Consent for use and Disclosure of Health Information

I understand that New Priorities Family Services will use and disclose health information about me. I understand That my health information may include information both created and received by this provider; records may be in the form of written, electronic or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatment, procedures, prescriptions and other similar types of health-related information.

I understand that I have the right to receive and review a written description of how New Priorities Family Services will handle health information about me. This written description is known as a Notice of Privacy Practices and describe the uses and disclosure of health information made and the information practices followed by the employees, staff, and other office personnel of **New Priorities Family Services** and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of the Notice of Privacy Practices in effect will be posted in the waiting area. 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 New Priorities Family Services is not required by law to agree to such requests.

By signing below, I (**Print Name**)________________________________agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices. **Please Initial the Following**…

1.) Do you have a Declaration for Mental Health Treatment and/or an Advanced Directive? __yes__No
2.) Would you like help completing a Declaration for Mental Health Treatment? __yes __no
3.) Would you like an info packet about DMHT? _____Yes _____ No
4.) Are you a registered Voter? _____Yes ______No
5.) Would you like a voters registration card? _____Yes _____No

Client/Representative Signature:____________________________________Date:___/___/____

Parent/Guardian:____________________________________Date:____/___/_____

For Office Use Only
I attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because: Emergency situation prevented obtainment of acknowledgement_ Communication barriers prevented us from obtaining acknowledgement_ Individual refused to sign Other (Please Specify) ____

January 23, 2019

Tobacco / Smoke-Free Property

NPFS is a Federal/State funded program and we have to abide by their rules and regulations. No smoking is permitted on the property at any time.

Just recently there was another fire along the side of our building. The Redmond Fire department determined that the fire was started by a cigarette that was thrown into the bark chips. We have had several incidents with the fire department response team in the last couple years and in order to avoid making emergency calls to the Redmond Fire Department due to cigarettes being tossed into the bark chips the Redmond Fire Marshall has advised us to create a Smoke-Free Property.

A building fire is an increasing concern and liability which could adversely affect NPFS, clients and families and/or potentially cause a closure of the business in the event of a fire.

HIGHLAND PLAZA / NEW PRIORITIES FAMILY SERVICES IS A SMOKE-FREE PROPERTY

Verbal Warning: If you are caught smoking on the property you will be asked to leave the property but may return back to NPFS after you are done smoking as long as it is non- disruptive to your scheduled appointment time, counselor, other clients and families.

Warning: If you continue to smoke on the property after your verbal warning you will be asked to leave the property and you may not return until your next schedule appointment and/or group.

Final Warning: You may be asked to seek services elsewhere.

New Priorities Family Services appreciates your understanding and cooperation in this matter

Sincerely,

Karen Ludwig, Director

By signing below, you acknowledge that you understand and agree to comply with the Smoke Fee policy.

____

Client Signature Print Name Date

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Notice of Privacy Practices

What are your privacy rights?

- You can ask to limit how we use or share your information. You must ask in writing. We can agree if law allows.
- You can ask us to contact you in a certain way or in a certain place. We will follow any realistic request.
- In most cases, you can look at or get copies of your records. You must ask in writing. You may have to pay for the copies. Please contact us for the form.
- You can ask to amend health information in your medical or billing records. This must be in writing. We may not agree to these changes in certain situations.
- You can ask us what health information we shared about you after April 14, 2003. You must ask in writing. This list will not have information we shared for treatment, payment, or health care operations that you gave permission to share.
- You can usually take back your written permission if you ask us in writing. We can't take back any information we have already given.

What is protected?

Protected Health Information (PHI), which means any medical information with your name on it.

Your Records: Are kept in a chart with your name on it. They can be stored in a computer. Tell what treatment and test you have had and what health care choices have been made.

Protecting your privacy: By law, we must keep your medical information private except in some situations. We must give you a copy of these rules. All Deschutes County Health Services Employees and volunteers must follow these rules.

When we need your written permission: *To share some information such as:* Mental health, Alcohol and drug abuse treatment, HIV/AIDS testing or treatment and Genetic testing information.

How we may share your PHI ***Medical Treatment****:* Information for payment. Your medical care. Appointment reminders. To tell you about services or treatment. DCHS Business Associates, Labs, Pharmaies and Interpreters. ***Special Situations:*** To talk to people who help for for your care. Workers Compensation. To schedule an interpreter for you. In the event of a disease. To report births or deaths. Healthcare emergency. Eminent threat to self or others. ***Legal purposes:*** For specific court request such as subpoenas. To report suspected abuse, neglect or domestic violence. For investigations or audits. To jails or prisons. For national security or to protect the President.

Privacy Complaints: We care about your concerns! If you do not agree with how we used or disclosed information about you, you may file a complaint. You will not be punished and your care will not be affected if you file a complaint.

To file a privacy complaint, please contact:

- NPFS Program Director; Karen Ludwig (541) 923-2654 Fax (541) 548-8099

1655 SW Highland Ave Suite 3, Redmond, Oregon 97756

- Deschutes County Risk Manager (541) 330-4631 Fax (541) 617-4704

1300 NW Wall St. Suite 200, Bend Oregon 97701

- Secretary of the Department of Health & Human Services Region 10 HHS

Voice phone (206) 615- 2290 TDD (206) 615-2296 Fax (206) 615-2297