

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: _____

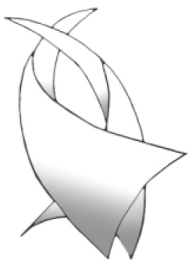
In your own words, list your weaknesses: _____

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: _____	



NPFS
New Priorities Family Services

1655 S.W. Highland #3
Redmond, Oregon 97756
541.923.2654
www.mynewpriorities.org
info@mynewpriorities.org

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

Cancellation / No Show Documentation Log	Date	Counselor Signature	Client Signature
Cancellation #1			
Cancellation #2			
Cancellation #3			
No Show #1			
No Show #2			

Providing counseling and educational services for at risk youth and their families.



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

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:

- Reporting suspected child abuse
- Reporting imminent danger to client or others
- You request my appearance in court to testify on your behalf
- License consultation or supervision
- Defense of claims brought by client against licensee
- 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: _____

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, Pharmasies 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

NEW PRIORITIES FAMILY SERVICES

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

(541)923-2654 Fax (541)5047017

www.mynewpriorities.com

Acknowledgement of Receipt of Notice of Privacy Practices

&

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) _____

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:

Providing counseling and educational services for at risk youth and their families.

Individual Rights

*Update June 2016

OAR 309-019-0115

- (1) In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:
- (a) Choose from available services and supports, those that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence;
 - (b) Be treated with dignity and respect;
 - (c) Participate in the development of a written Service Plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written Service Plan;
 - (d) Have all services explained, including expected outcomes and possible risks;
 - (e) Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.
 - (f) Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:
 - (A) Under age 18 and lawfully married;
 - (B) Age 16 or older and legally emancipated by the court; or
 - (C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs;
 - (g) Inspect their Service Record in accordance with ORS 179.505;
 - (h) Refuse participation in experimentation;
 - (i) Receive medication specific to the individual's diagnosed clinical needs;
 - (j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
 - (k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
 - (l) Have religious freedom;
 - (m) Be free from seclusion and restraint;
 - (n) Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;
 - (o) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented;
 - (p) Have family and guardian involvement in service planning and delivery;
 - (q) Make a declaration for mental health treatment, when legally an adult;
 - (r) File grievances, including appealing decisions resulting from the grievance;
 - (s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
 - (t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
 - (u) Exercise all rights described in this rule without any form of reprisal or punishment.
- (2) Notification of Rights: The provider must give to the individual and, if appropriate, the guardian, a document that describes the applicable individual's rights as follows:
- (a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;
 - (b) The rights, and how to exercise them, must be explained to the individual, and if appropriate, to her or his guardian; and
 - (c) Individual rights must be posted in writing in a common area.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 426.205 - 428.270, 430.640 & 443.450

Stats. Implemented: ORS 109.675, 161.390-161.400, 179.505, 413.520 - 413.522, 426.380-426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010-813.052 & 813.200-813.270

Hist.: MHS 6-2013 (Temp), f. 8-8-13, cert. ef. 8-9-13 thru 2-5-14; MHS 4-2014, f. & cert. ef. 2-3-14; 20-15; MHS 3-2015, f. & cert. ef. 5-28-15

I have received a copy of this document. Client name: (print) _____ Date: _____