NPFS
New Priorities Family Services
With hope, with change, brings new life.

Individual Information Form

Individual Information of person receiving services

Individual's Name:_____ Email:_____
Address:_____ City/Zip:_____
Home:_____ Cell:_____Work:_____
DOB:_____ Age:_____ Sex:_____ Social Security Number:_____
Employer:_____Occupation:_____
Emergency Contact:_____ Relationship: _____Phone#_____
Resides in _____ (City) _____ (State)
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: _____ DOB: _____ Sex:____SSN:_____
Employer: _____ Occupation:_____ Work#_____
Address: _____City/Zip:_____ Home/cell#_____

Spouse/Significant Other Information:

Name: _____ DOB: _____ Sex:____ SSN:_____
Employer:_____ Occupation:_____ Work#_____
Home/Cell#_____

Family Physician: _____ Location:_____ Phone#_____
Family Dentist: _____ Location:_____ Phone#_____

Insurance Information:

Health Insurance Plan:_____ Policy Holder:_____
ID#_____
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.

_____

Signature of client or parent/legal guardian Date

Providing Mental Health and Substance Abuse counseling services for youth, adults, and their families.

NEW PRIORITIES

MOTS DATA ENTRY FORM & REQUESTING AUTH. (Mental Health)

<table>
<tr><td colspan="2">Service Date:</td><td>Client Record Number:</td><td colspan="2">Counselor's Name:</td></tr>
<tr><td colspan="5">PATIENT INFORMATION</td></tr>
<tr><td colspan="2">Last Name:</td><td>First Name:</td><td>Middle Int.</td><td>Last Name at Birth:</td></tr>
<tr><td>Date of Birth:

Gender:
MALE FEMALE

Marital Status: (Circle)
NM M Div Wid Sep</td><td>Race: (Circle)
White
American Indian
*Tribe Affiliation:
_____
Alaska Native
Asian
Black or African American
Native Hawaiian/Pac Island
Other (single race)
Two or more races</td><td colspan="2">Ethnicity: (Circle)
Not of Hispanic Origin
Cuban Hispanic
Origin Mexican
Unknown

Living Arrangement: (Circle)
Home Relative Friend
Homeless Other</td><td>Employment (Circle)
Full Time Part Time
Disable Retired
Home Maker
Unemployed
Self Employed
Not in Labor Force
Student
Other Reported Classification</td></tr>
<tr><td>Veteran: (Circle)
Yes No</td><td>County of Residence:</td><td colspan="2">Zip Code:</td><td>Gross Monthly Household Income:
$_____</td></tr>
<tr><td>Number of Dependents:

Pregnant: (Circle)
Yes No</td><td>Highest School Grade Completed:

Tobacco Use: (Circle)
Yes No</td><td colspan="2">School Improvement (Circle)
Academic Yes No
Attendance Yes No
Behavior Yes No
NA</td><td>Source of Income: (Circle)
Wage/Salary
Public Assistance
SI/Disability
Retirement
Other</td></tr>
<tr><td colspan="5">FOR COUNSELOR USE:</td></tr>
<tr><td colspan="5">Infectious Disease Risk Assessment: (Circle one) Low-Risk Med-Risk Med-High Risk Referral Made Not Completed</td></tr>
<tr><td colspan="3">Legal Status:</td><td colspan="2">Substance Use Last 90 days (Circle one): Yes No Ukn</td></tr>
<tr><td colspan="3">Client Insurance ID (alpha):</td><td colspan="2">Diagnosis:</td></tr>
<tr><td colspan="3">Referred From:</td><td colspan="2">Referred To:</td></tr>
<tr><td colspan="3">Treatment Plan Indicator: (Circle)
Education Employment
Housing Other:
_____</td><td colspan="2">Client Treatment Status: (Circle one)
Active Assessment only TX Compete
Transferred Left Against Professional Advice
Service Terminated by Facility</td></tr>
<tr><td colspan="5"></td></tr>
</table>

_____

Lynnelle, Mots Entered Date

Revised 05/1/2019

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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Confidential Personal Data Intake Form

Date:_____ Name: _____ DOB:_____ Age:_____

Major issue you want to discuss:_____

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

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	Sometimes/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 and to avoid cancellation fee.

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 time for you to engage in therapy.

Acknowledgement

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

_____

Signature of client or parent/legal guardian Date

_____

Counselor Signature Date

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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.

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 scheduled 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-Free Policy.

_____

Client Print Name Signature of client or parent/legal guardian Date

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Declaration for Treatment

Please initial on the following to indicate a Yes or No answer	Initial Yes	Initial No
Do you have an Advance Directive?	____	____
Do you have a Declaration for Mental Health Treatment?	____	____
Would you like help completing a Declaration for Mental Health Treatment?	____	____
Would you like an info packet about Declaration for Mental Health Treatment?	____	____
Are you a registered voter?	____	____
Would you like a voter's registration card?	____	____

_____

Client/Representative Name Signature Date

_____

Parent/Guardian Signature Date

Visit these websites for more information on Declaration of Mental Health Directive and Advanced Directive

www.Oregon.gov/oha/amh/pages/services/planning.aspx
www.Oregon.gov/DCBS/insurance/shiba/Documents/advancedirectiveform.pdf

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 us from obtaining acknowledgement _____Communication barriers prevented us from obtaining acknowledgment _____ Individual refused to sign_____ other (please specify)_____

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Acknowledgement of Receipt of Notice of Privacy Practices
&
Consent for use and Disclosure of Health Information

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 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, diagnosis, treatment, procedures, prescription 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 describes 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 Practices. I also understand that a copy or summary of the most current version of the Notice of Privacy Practices 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 request.

By Signing below I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

_____

Client Print Name Signature of client or parent/legal guardian Date

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Contract For Psychotherapy Services

Full payment or your Co-pay is expected at the time of service. Payment plans can be arranged with the billing department. Self-pay fees and/or co-pay assistance may be available depending on your income and circumstances. In the event you may need assistance please discuss your circumstances with your counselor. _____(**Initial**)

Payment Options: Currently we can accept cash, checks, Visa/MC debit cards, and HSA cards. Be aware that there will be a charge of $50.00 for returned checks due to insufficient funds. 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 Insurance Policy and the services it provides and covers. Some 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 your insurance.

Reprocessing of Claims: Failure to notify NPFS of any changes to your billing information and/or insurance coverage within 10 days will result in an additional reprocessing fee of $50.00 but not limited to based on the lapse in notification of changes to NPFS.

You will be financially responsible should your insurance deny any claims for services rendered at NPFS. Additional fees will apply if payment to NPFS is not made and balance is transfered to our third party collections agency.

Mental Health

- Initial Evaluation/Consultation $270
- Individual Therapy (30 min.-1hr) $120-$240
- Family Therapy $205-$240
- Group Therapy $70
- OHP Individuals - Cost of services set by State

Chemical Dependency

- Alcohol/Drug Assessment $270
- Individual Session (1-4 units) $60-$240
- Family Therapy $145-$240
- Group Therapy $70
- UA Collection Fee $25

Appointments: Your appointment time is a commitment between you and NPFS to provide you the services needed. This time is YOURS. Therefore, we ask that you give a 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 cancellation fee of $50.00 for No Call/No Show (OHP exempt).

I have read and understand the contract obligation stated above

_____

Client Print Name Signature of client or parent/legal guardian Date

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Grievance Policy and Procedures

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.

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

- State of Oregon Health Authority 503-945-5772
- Disability Rights Oregon 503-243-2081
- Pacific Source Grievance and Appeals 1-888-863-3637
- The Governor's Advocacy Office 503-945-6904

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 State of Oregon Helath Authority.

Oregon Health Authority 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 Division Director.

I have read and reviewed a copy of this document

_____

Client Print Name Signature of client or parent/legal guardian Date

Individual Rights

*Updated October 2019

(1) In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:

(a) Choose from services and supports that are consistent with the assessment and 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 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 (Authority of parent when other parent granted sole custody of child), 179.505 (Disclosure of written accounts by health care services provider), 179.507 (Enforcement of ORS 179.495 and 179.505), 192.515 (Definitions for ORS 192.515 and 192.517), 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 (Disclosure of written accounts by health care services provider);

(h) Refuse participation in experimentation;

(i) Receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence;

(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) Have an opportunity to 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 (Right to care for certain sexually transmitted infections without parental consent) through 109.697 (Right to contract for dwelling unit and utilities without parental consent) if the individual is a child, as defined by these rules;

(t) Exercise all rights set forth in ORS 426.385 (Rights of committed persons) 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) The provider shall 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 shall 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 shall be explained to the individual, and if applicable the guardian; and

(c) Individual rights shall be posted in writing in a common area.

I have received a copy of this document

_____

Client Name | Signature of client or parent/legal guardian | 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 Service 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 you PHI Medical Treatment: Information for payment. Your medical care. Appointment reminders. To tell you about services or treatment. DCHS Business associates, Labs, Pharmacies, and Interpreters.

Special situations: to talk to people who help 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, OR, 97756

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

1300 NW Wall St. Suite 200, Bend, OR, 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

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Consent to Treatment

I,_____ / _____
(First, Last Name) (Date of Birth)

am voluntarily requesting services with New Priorities Family Services (NPFS). I understand and agree that NPFS may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to and/or consult with Director, along with other health care providers, including other providers within NPFS, for my care and treatment.
- Determine my eligibility for insurance coverage, submit bills, claims and other related information to my insurance company or others who may be responsible to pay for some or all my health care.
- I am freely choosing to enter treatment, and I understand that I may discontinue treatment at any time.

I give my authorization and consent to receive outpatient diagnostic and treatment services from New Priorities Family Services and _____.
(Assigned Counselor)

- I have been given information regarding my rights and responsibilities as a client.
- I have been given information regarding the limits of confidentiality of my records.
- I have been given information regarding the cost of the services from NPFS and I agree to pay all charges not paid by my insurance or any other payer source. If legal proceedings are required to collect this account, I agree to pay all collection fees.
- I understand that I may address any concerns or grievances with my therapist or any other representative of NPFS.
- I understand that I may also contact the licensing board, which regulates my therapist's professional practice.

_____

Signature of client or parent/legal guardian Date

_____

Witness Date

Providing Mental Health and Substance Abuse counseling services for youth, adults, and their families.