BEHAVIORAL HEALTHCARE NW
PATIENT INFORMATION

Provider Name:_____ **Date**:_____

1. **Patients Full Name:** _____ **Marital Status:** M/P S W D Sep
2. **DOB:**_____ **Age:**_____ **Sex:** M F **Religious/Other Affiliation:**_____
3. **Phone:**_____ **Cell:**_____ **Other:**_____
4. **Mailing Address:**_____ **Own:** ___ **Rent:** ___
5. **City:**_____ **State:**_____ **Zip:**_____
6. **Email:**_____ **Drivers License#:**_____
7. **Occupation:**_____ **Employer:**_____
8. **Who recommended this office?:** _____
9. **Primary Care Providers (Physicians/Other):** _____

Address:_____ **City/State/Zip:**_____
Phone: _____ **Fax:** _____

Primary Care Providers (Physicians/Other): _____
Address:_____ **City/State/Zip:**_____
Phone: _____ **Fax:** _____

10. **Spouse or Parent(s):**_____ **DOB:**_____

11. Others living at home:
Name:_____ **DOB:**_____ **Relationship:**_____
Name:_____ **DOB:**_____ **Relationship:**_____
Name:_____ **DOB:**_____ **Relationship:**_____

12. **Emergency Contact:** _____ **Relationship:**_____
Emergency Contact Number(s):_____

MEDICAL INSURANCE SECTION:
13. **Primary Insurance:** _____ **Phone:**_____

Address:_____ **City/State/Zip:**_____
Subscriber's Name: _____ **Subscriber's DOB:**_____
ID #:_____ **Group #:** _____
14. **Secondary Insurance:** _____ **Phone:**_____

Address:_____ **City/State/Zip:**_____
Subscriber's Name: _____ **Subscriber's DOB:**_____
ID #:_____ **Group #:** _____

I hereby authorize the release of medical information necessary for claims processing, and assign all insurance benefits to the billing therapist.

X: _____ **Date:** _____

Assumption of Responsibility for adult children:
I agree to be responsible for professional expense incurred by _____
from the period beginning _____. **Date:** _____

X: _____ **Relationship:**_____

BEHAVIORAL HEALTHCARE NW
PATIENT HISTORY

PRESENTING PROBLEMS:
Please describe the problem(s) and/or reason(s) for initiating the appointment:

PLEASE INDICATE ANY CURRENT APPLICABLE SYMPTOM(s):

Depression		Thoughts about Hurting Yourself or Others	
Extreme Sadness		Feeling Hopeless	
Trouble Concentrating		Feeling Tearful	
Memory Problems		Change in Sleeping Habits	
Change in Eating Habits		Lack of Energy	
Feeling Extreme Happiness		Weight Changes	
Trouble Preforming Your Job/Daily Routine		Change in Sexual Interest or Function	
Lack of Enjoyment of Usual Activities		Problems Getting Along with Friends or Family	
Self-Esteem Problems		Feeling Stressed	
Perfectionism		Easily Irritated	
Obsessions or Compulsions		Feeling Guilty	
Feeling Fearful		Feeling Nervous	
Physical Complaints of Pain		Sudden Feelings of Panic	
Problems with Anger		Muscle Tension	
Acting Violently		Thoughts About Killing Yourself or Others	

BEHAVIORAL HEALTHCARE NW
PATIENT HISTORY continued.

COUNSELING HISTORY

1. Have you ever been to counseling before? Yes ☐ No ☐
   If yes, please describe it below. Begin with your most recent time first.
2. When did you have counseling? Date(s): _____ _____ to _____ _____
   (MONTH) (YEAR) (MONTH) (YEAR)

Who did you See? Name: _____
Explain what happened:

3. When did you have counseling? Date(s): _____ _____ to _____ _____
   (MONTH) (YEAR) (MONTH) (YEAR)

Who did you See? Name: _____
Explain what happened:

MEDICAL INFORMATION

1. Have you seen a doctor within the past year? Yes ☐ No ☐
2. Who is your doctor? Name:_____
3. Why have you seen a doctor?
4. Are you taking any kind of medication (prescription or over-the-counter)? Yes ☐ No ☐
5. Please list the medications that you are currently taking:
   -
   -
   -
   -
   -
6. Do you have any allergies? Yes ☐ No ☐
7. Please describe any allergies that you may have:

8. SUBSTANCE USE HISTORY

1. Do you use/have used tobacco (any form)?	Current ☐	Past ☐	No ☐
2. Do you use/have used alcohol?	Current ☐	Past ☐	No ☐
3. Do you use/have used caffeine (any form, including cola drinks)?	Current ☐	Past ☐	No ☐
4. Do you use/have used recreational drugs?	Current ☐	Past ☐	No ☐

BEHAVIORAL HEALTHCARE NW
INFORMED CONSENT TO TREATMENT, OFFICE PROCEDURES & FINANCIAL AGREEMENT

INFORMED CONSENT TO TREATMENT

1. Please feel free to ask questions about any aspect of the counseling processes.
2. If you have been referred by a court or state agency, although you have the right to divulge only what you want to be included in a report, it may affect how the court or agency decides the matter that led to your referral.
3. You will need to be willing to discuss what troubles you and be open to change.
4. You may remember unpleasant events, arouse intense emotions and/or alter close relationships.

CONFIDENTIALITY

1. Information shared will be held in confidence. It will not be released without your written consent, except for professional consultation if needed, and unless required by law.
2. We are required by law to disclose information pertaining to suspected child, dependent adult, and elder abuse, inability to care for one's basic needs for food, clothing, or shelter, and threatened harm to oneself or others. Lawyers may, in select cases, subpoena counseling records.
3. Information regarding treatment and diagnosis may be provided to your insurance company(-ies) for reasons among which include case review, payment review, benefit management, etc.
4. If you have any concerns about disclosure of confidential medical information, please discuss this with your provider.
5. Electronic communication is reserved for administrative purposes only. Any information shared via email, or other electronic platform is not confidential. Although we strive to maintain the highest level of security and confidentiality, **email is private but not guaranteed confidential. Please do not send confidential information via email.**
6. Social media and other similar platforms are not used to respond, schedule, or communicate. Please call the front desk for any inquiries, or to schedule an appointment. Electronic communication may put your privacy at risk, and can be inconsistent with the law and standards of this profession. **Although you are welcome to view our Facebook page, (BehavioralhealthcareNW), it is for your convenience to inform of general inquiries only; commenting, messaging, posting, etc. functions are disabled.** Additionally, we do not encourage or suggest you to "like" our Facebook page, as it creates a greater likelihood of compromised client confidentiality. "Liking" our Facebook page may compromise your privacy depending on your personal settings. There is a possibility that your other "friends" may see the companies you have "liked."

LEGAL EVALUATIONS

1. If you are involved in or anticipate being involved in legal or court proceedings, please notify your provider as soon as possible. It is important for them to understand how, if at all, your involvement in these proceedings might affect our work together.
2. In the event that you are entering treatment because you have been asked to obtain a psychological evaluation, it is important for you to know the difference between treatment and an evaluation, and to recognize that treatment is not a substitute for an evaluation or an appropriate method to obtain evaluation results. If you need an evaluation we will be happy to assist you to find a provider that offers this service.

EMERGENCIES

1. In case of an emergency please dial 911 or the Multnomah County Crisis Hotline at 503-988-4888.
2. During normal business hours you may call our office at **503-252-9690**. Please indicate to the receptionist, this is an emergency or crisis situation.
3. If the front desk is unavailable, you may contact our 24-hour confidential answering for emergency use only (**503-294-1555**).

APPOINTMENTS

1. All office visits are by appointment only and are scheduled with our receptionist (or your provider). Please arrive 5-10 minutes early, as you may lose minutes from your appointment time when you arrive late. The length of time for an evaluation or psychotherapy appointment is dependent upon your insurance coverage, but usually 45-55 minutes.
2. All appointments must be in-person & in-office. Phone, Skype, home & hospital sessions are not scheduled. In emergency situations, alternative arrangements may be discussed with the prescribing therapist on a case-by-case basis, however, we cannot bill insurance in these situations.
3. **Our Cancellation and/or No-Show Appointment Policy requires twenty-four (24) hours notice, or by noon on Friday (for Monday appointments) if an appointment must be canceled or rescheduled. Late cancellations or no-shows are subject to a $90 fee. The full payment of this fee is your responsibility, as it is not covered under insurance billing.**
4. In the case of illness, please notify our receptionist as soon as possible and no later than 8:30 A.M. on the day of your appointment. Please leave a voicemail message if our office is closed. Our voicemail is confidential. You will not be charged when ill, but please give as much notice as possible to allow your appointment to be filled from the cancellation list.
5. If your appointment is canceled or missed, please re-contact our office for a new appointment time.

HOURS OF OPERATIONS

Front Desk Hours:
M-Th: 8:00 AM - 4:00 PM
F: 8:00 AM - 12:00 PM
Sat & Sun: Closed

Appointment Hours:
*Appointments may be scheduled depending on therapist availability
M: 8:00 AM - 7:00 PM
T: 7:00 AM - 4:00 PM
W: 7:00 AM - 7:00 PM
Th: 7:00 AM - 4:00 PM
F: 7:00 AM - 1:00 PM

FEES

1. Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
2. Patients paying on a cash basis (not billing any insurance) are expected to make payment in full at the time of service, unless a payment plan has been previously arranged. We accept credit card, personal checks and cash.
3. Our office will bill your health insurance company if complete information is provided and proper authorization was obtained prior to the visit. Please verify whether your coverage includes outpatient psychotherapy by our licensed professional. If your policy requires pre-authorization to receive services, our office can assist you, but it is your responsibility to insure that it is handled prior to the visit. You are ultimately responsible for payment of your account.
4. Insurance billing only covers office visits. Although the therapist may answer phone calls in crisis situations or on a case-by-case basis to answer questions or touch base, phone calls, Skype calls, home or hospital visits cannot be billed to insurance and are generally not scheduled.
5. Patient portions, co-payments, and/or deductibles are due at the time of service. You will only receive statements if patient portions are due after insurance claims are processed. Please pay statement balances are due by the 20th of the month. Please pay balances in a timely manner.
6. Accounts become delinquent after thirty (30) days. Delinquent accounts may be sent to a collection agency, unless prior arrangements and/or payment plans are made with the Dr. or billing company.

Please discuss any questions or concerns regarding these policies with the receptionist or treating therapist.

Initial _____ I have read, understood and agree to these policies and give consent for treatment.
Initial _____ I have been given an opportunity to discuss these policies and have declined treatment.

Signed:_____ **Date:**_____