NEW PERSPECTIVES CENTER
for Counseling and Therapy

565 Union St. NE Suite 105
(503) 316-6770

1675 Winter St. NE
(503) 316-6770

Individual Information **Date** ____________________

Legal Name: ____

Preferred Name:________________________ **Maiden Name:** ____________________

Mailing Address: ____

City: ____________________ **State:** __________ **Zip:**__________ **County:** __________

Physical Address (if different than mailing address): ____________________________

City: ____________________ **State:** __________ **Zip:**__________ **County:** __________

Phone: ( ) ______________ **Work Phone:** ( ) ______________ **Cell:** ( ) ______________

Date of Birth: ____/____/____ **Social Security Number** ____________________

Email Address:____

Emergency Contact: ______________________ **Phone Number:** ( ) ______________

Mailing Address: ____

Referred by: ____

Primary Care Physician: ______________________ **Phone:** ( ) ______________

Address: ____

Pharmacy:______________________ **Address:**______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Living as Married

Gender: ☐ Male ☐ Female ☐ Other **Legal Gender:** ☐ Male ☐ Female ☐ Other

Employer or School: ______________________________ **Employed:** ☐ Full-Time ☐ Part-Time ☐ Student ☐ Non-Employed

Highest Grade Completed: ______________

Occupation: ____

Parent's/Partner's Name: ____

Parent's/Partner's Employer: ______________________ Work Phone: ( ) ______________

Legal Guardian (if applicable) Name/Agency: ______________________ Phone: ( ) ______________

Address: ____

Is the individual covered by insurance? ☐ Yes – Go to section II ☐ No – Go to section V

Section II – Insured Information ____

Individual Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

If "Individual Relationship to Insured" is other than "Self" please complete the section below. If individual (the one becoming a client with NPC) is the one insured, go directly to Section III.

Name: ____

Address: ____

City: ______________________ State: ________________ Zip: __________________

Phone: (   ) ______________________ Work Phone: (   ) ______________________

Date of Birth: _____/_____/_____ Social Security Number: _______________________

Marital Status: ☐ Single ☐ Married ☐ Other   Gender: ☐ Male ☐ Female

Employer or School: ____

☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Section III – Insurance Policy Information ______________________________________

☐ Medicare ☐ Oregon Health Plan ☐ Private Group Health Plan ☐ Other

Insurance Company: ____

Address: ____

City: ______________________ State: ________________ Zip: __________________

Phone: (   ) ______________________

Plan Name: ____

Policy Number: __________________________ Group Number: ____________________

Is the Individual covered by more than one insurance?

☐ Yes – **Please complete Section IV**

☐ No – Please return this form to the receptionist

Section IV – Secondary Insurance Policy Information ____________________

☐ Medicare ☐ Oregon Health Plan ☐ Private Group Health Plan ☐ Other

Insurance Company: ____________________

Address: ____________________

City: ______________ State: ____________ Zip: ____________

Phone: (   ) ______________

Plan Name: ____________________

Policy Number: ______________ Group Number: ______________

Section V – Billing Information ____________________

Who is responsible for charges for this Individual?

☐ Individual (client) – Please return this form to the receptionist

☐ Other-Please complete the information below: (please note that whomever signs the Individual Client Agreement will also be held responsible for all charges)

Name: ____________________

Address: ____________________

City: ______________ State: ____________ Zip: ____________

Phone: (   ) ______________ Work Phone: (   ) ______________

Date of Birth: _____/_____/_____ Social Security Number: ______________

Employer: ____________________

Marital Status: ☐ Single ☐ Married ☐ Other Gender: ☐ Male ☐ Female

Relationship to Individual: ____________________

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CLIENT AGREEMENT

In an effort to keep mental health costs down while maintaining a high level of professional care, we have established the following payment policy for our clients. Our primary responsibility is to help our clients experience good health and we wish to spend our time and energy toward that end. Therefore, we would like to take the time now to fully explain our policy to you in order to avoid any misunderstanding in the future.

- **All fees are due and payable at the time of your visit.**

- We do accept insurance as full or partial payment of the fee and will be happy to bill the insurance carrier for you. Even though you have an insurance claim pending, you will receive a statement each month for the outstanding balance of your account. **We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier.** You are responsible for payment of your account within the usual limits of our credit policy. After 90 days, delinquent accounts may be assigned for collection assistance. If this becomes necessary, a $25 service charge will be added to the account to cover the costs of the additional handling required. This will ensure that our clients who keep their accounts current will not be penalized to cover the costs incurred by those who don’t pay.

- **We require a 24-hour notice of cancellation of your appointment; otherwise you will be charged $35.00 for the session.** A missed appointment is wasted time for all involved, and the 24-hour notice gives us an opportunity to reschedule that time with someone else that needs to be seen. We have an answering machine that operates 24 hours a day, seven days a week so that you can leave a message anytime, nights and weekends included.

- **Telephone calls other than to make or change appointments will be billed at the regular rate.**

- We may need to bill you if we are required to make outside consultations that are not covered by insurance (i.e. insurance reviews, school counselors, physicians, court, attorneys, etc.).

Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult with us if you have any questions regarding our services and fees. It is not our intention to cause you undue hardship. However, we must collect our receivables as efficiently as possible in order to continue our service to the community.

I have read this credit policy and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limits of this credit policy. I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees, including collection costs, attorneys’ fees, and all court costs.

Client Name: ____

Client/Parent/Guardian Signature: ____ **Date:** ____________

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RISKS VS. BENEFITS

As in anything new, there are inherent risks in a treatment relationship. Due to the intense nature of self-evaluation and awareness, clients typically experience a range of emotions coupled with periods of imbalance. These periods lend themselves to states of confusion and disorganization. However, as in any growth process, the ups and downs usually balance out. If you choose not to seek treatment or outside assistance, you may find that doing nothing results in no change of your condition or behavior.

CONSENT TO TREATMENT

I have requested treatment from New Perspectives Center for Counseling and Therapy (NPC). I understand that testing, diagnostic procedures, and therapy are determined and administered through professional judgments made by NPC Staff. This treatment may include individual and/or group therapy, and may include consultations with NPC Counselors, Prescribers and other NPC staff. I understand that treatment procedures will be developed according to a mutually agreed upon treatment plan between me, my child (if receiving treatment) and the New Perspectives staff. I also understand that I will be given an explanation of the purpose of any prescribed medication and potential side effects.

If I use a WVCH contracted transportation service, I understand that NPC staff will be confirming appointments with them.

I understand that I am free to withdraw from this relationship at any time, and I agree to attend a closing session upon termination of treatment. I also understand that I am free to file a grievance at any time.

FEES

I also acknowledge that I have received a copy of the current fee schedule for New Perspectives Center.

Counseling fees per session are:

Initial Session	$200.00	Over 53 Minutes	$175.00
16-37 minutes	$ 88.00	Group Sessions	$ 60.00 per group
38-52 minutes	$120.00	Couples/Family Counseling	$175.00 per 50 min.

Medication Management Fees Initial Assessment $390.00
Ongoing fees to see a prescriber will vary depending on time spent and services provided

NO SHOW / LATE CANCEL FEE $35.00 ------ NSF / BOUNCED CHECK FEE $20.00

<u>Except for Oregon Health Plan Clients:</u>
Phone consultations with the therapists are billed at $32.00 per 15 min. and are not billable to your insurance company. Case Management fees are billed at $29.50 per 15 min. and are not billable to your insurance company.

PAYMENT OF FEES

You are responsible for the payment of all charges incurred. We are happy to assist you by billing your insurance company but since your policy is a contract between you and your insurance company, you need to remember that any benefits information quoted by us regarding co-payments, deductibles and available benefits is only based on what was told to us by your insurance company at the time you schedule your first appointment. Benefits are normally subject to patient eligibility, contract limitations and exclusions in effect at the time the service is rendered. If you have any questions, contact your insurance company for clarification on your benefit package.

You will receive a monthly statement of your account showing services and payments received by you and/or your insurance company. Prompt payment of any outstanding balance is requested.

<u>If you are on the Oregon Health Plan</u> *– As long as Oregon Health Plan coverage is in place, clients are not responsible for fees incurred during that time but are responsible for any charges incurred after coverage is lost. If you are an OHP client and your coverage is terminated, New Perspectives Center will work with you to assist you in finding alternative resources for coverage and identifying if any other financial assistance programs are available.*

Client Name: ____ Date: __________________

Client or Parent/Guardian Signature: ____

NEW PERSPECTIVES CENTER

for Counseling and Therapy

INDIVIDUAL'S RIGHTS

New Perspectives Center supports and protects the fundamental human, civil, constitutional and statutory rights of each individual. Every individual will be treated with dignity and respect. Our agency provides each individual with a copy of their rights.

The following is a list of Individual's Rights:

1. Individuals have the right to admission to the treatment center without regard to race, religion, gender, ethnicity, age, AIDS, duration of residence, national origin or disability.
2. Each individual is entitled to individualized treatment that provides the greatest degree of independence, the least restrictive and/or intrusive environment therapeutically possible and adequate services to meet these rights.
3. Each individual is entitled to an individual treatment plan, developed by the individual, individual's counselor, and periodically reviewed by the entire staff for ongoing appropriateness.
4. Each individual has a right to receive care provided by a clinical staff that is competent, qualified and experienced.
5. Each individual has a right to individual privacy within the constraints of the individual service and support plan.
6. Each individual has the right to receive in writing a copy of all information pertaining to the program and its daily operation and functions.
7. Each individual has the right to be informed of any special observation and audiovisual techniques of equipment that are used in the therapeutic process of the program.
8. Individuals have the right to be aware in advance of any outside visitors to the facility.
9. Individuals have the right to anonymity and confidentiality.
10. Individuals will not be expected to provide labor for New Perspectives Center.
11. Individual has the right to refuse treatment unless court ordered.
12. Individuals have the right to access copies of their records within 5 working days upon written request. Only records generated by New Perspectives staff can be accessed or copied.

Oregon Health Plan and Mid Valley Behavioral Health Plan clients have additional rights and responsibilities that are posted and available in handout form in each office and on the MVBCN website.

Individual's Grievance Procedure follows:

A copy of the full Grievance Procedure is given to each client at the first visit and upon request.

A. Any complaint/grievance which is not mutually resolved between individuals or between individuals and staff shall be communicated to any staff member of New Perspectives Center either in writing or orally so that it can be reduced into a clear, concise written report.
B. In response to receipt of such complaint/grievance, the Complaints Officer and/or Director shall immediately investigate and notify you within 5 working days following receipt of results or status of process.

____ ______________

Client Name Date

____ ______________

Client or Parent/Legal Guardian Signature (if appropriate) Date

NEW PERSPECTIVES CENTER
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PCP COMMUNICATION

You or your child has enrolled in services with New Perspectives Center. As part of your treatment, Oregon law mandates that we communicate with your Primary Care Physician to coordinate your behavioral, physical and mental health needs. You do not need to sign any additional releases of information. This communication will continue throughout the course of your treatment here. Shared information will include, but is not limited to:

- Prescribed medications
- Significant changes in medications or treatment approach
- Diagnosis and HIV status
- Termination of services

I have read and understand the above information.

____
Client Name (printed)

____ ________________
Client/Guardian Signature Date

ACKNOWLEDGEMENT AND CONSENT

I understand that New Perspectives Center may use and disclose health information about me. I understand that this may include information both created and received by the practice/facility and may be in the form of written or electronic records or spoken words. In addition, the disclosure may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that New Perspectives Center may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support the provider/practitioner's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective healthcare.

I also understand that I have the right to receive and review a written description of how New Perspectives Center will handle health information about me. The written description is known as a Notice of Privacy Practices. This document contains my rights regarding my health information. In addition, it describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of New Perspectives Center.

I understand that the Notice of Privacy Practices may be revised as needed, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of the New Perspective Center's Notice of Privacy Practices will be posted in the waiting/reception 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 Perspectives Center is not required by law to agree to such requests.

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 Name

____
Client or Parent/Guardian Signature Date

____
Relationship to Client

NEW PERSPECTIVES CENTER
SYMPTOM CHECKLIST

Client Name: ______________________________________ Date: _____________________________

Please check off any symptoms that you have experienced in the past year:

- ☐ Depressed mood
- ☐ No interest/pleasure in activities
- ☐ Feeling fatigue/loss of energy
- ☐ Change in appetite
  - o Increased
  - o Decreased
  - o Weight change
- ☐ Sleep problems
  - o Too much
  - o Difficulty getting to sleep
  - o Frequent waking
  - o Waking, unable to get back to sleep
  - o Feeling no need for sleep
- ☐ Agitation, restlessness
- ☐ Feeling of worthlessness
- ☐ Feeling of extreme guilt
- ☐ Difficulty concentrating, thinking, decision making
- ☐ Suicidal thoughts
  - o Plans
  - o Attempts
- ☐ Extreme irritability
- ☐ Racing thoughts
- ☐ Easily distracted, difficulty finishing tasks
- ☐ Extremely elevated mood
- ☐ Excessive energy/activity level
- ☐ Frequent harmful activities *(gambling, drug, alcohol)*
  Frequency: ______________________
- ☐ Excessive worry/fear
- ☐ Panic attacks
  Frequency: ______________________
- ☐ Recurrent/persistent disturbing thoughts
- ☐ Repetitive behaviors – compelled to do
- ☐ "On edge" or easily startled
- ☐ High anxiety
- ☐ Nightmares
- ☐ Flashback/trauma easily triggered by other events
- ☐ Easily angered/angry outbursts
- ☐ Feelings of emotional numbness/detachment
- ☐ Hallucinations
- ☐ Problems beginning or keeping relationships
- ☐ Thoughts or experiences seem strange/odd
- ☐ Memory problems
  - o Remembering last day or two
  - o Remembering distant past

Please describe any other symptoms that you have been experiencing:

____
____
____
____
____
____
____
____
____

CLIENT NAME:____

Landline (home) phone number:_________________________________
Cell phone number 1:____________________ This number belongs to (name):__________________
Cell phone number 2:____________________ This number belongs to (name):__________________

Work number 1:________________________ This number belongs to (name):__________________
Work number 1:________________________ This number belongs to (name):__________________

Email address:____
This email belongs to (name):_____________________________________

REMINDER RELEASE:
Please check one (1) option below for how you would like reminders.
You can refuse to have a reminder.

- ❑ **I do NOT want an appointment reminder**
- ❑ Phone reminder Only
  - ➢ Please call my (circle one): Landline Cell #1 Cell #2 Work #1 Work #2
- ❑ Text Reminder Only
  - ➢ Please text (circle one): Cell #1 Cell #2
- ❑ Email Reminder Only
- ❑ Email and Phone Reminder
  - ➢ Please call my (circle one): Landline Cell #1 Cell #2 Work #1 Work #2
- ❑ Email and Text Reminder
  - ➢ Please text my (circle one): Cell #1 Cell #2

(Sorry, Phone and Text reminders together is not an option)

***By Signing below, I am authorizing New Perspectives Center to remind me of appointments. I can request that New Perspectives Center stop sending reminders to me at any time.**

____

(Client Signature/Guardian signature if client is a minor) (Date)