NEW PERSPECTIVES CENTER

for Counseling and Therapy

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.

I understand that I will be given the opportunity to complete a Declaration for Mental Health Treatment.

If I use a CCO 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	$205.00
16-37 minutes	$ 99.00	Group Sessions	$ 60.00 per group
38-52 minutes	$135.00	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

Except for Oregon Health Plan Clients:
Phone consultations with the therapists are billed at $35.00 per 15 min. and are not billable to your insurance company. Case Management fees are billed at $34.00 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.

If you are on the Oregon Health Plan *– 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: _____

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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, handicap, national origin or duration of residence;

2. Each individual has a right to receive care provided by a medical/clinical staff member that is competent, qualified and experienced.

3. You have the right to choose from available services and supports, those 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 your liberty, that are least intrusive to you and that provide for the greatest degree of independence;

4. You have the right to be treated with respect and dignity;

5. You have the right to 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;

6. You have the right to have all services explained, including expected outcomes and possible risks;

7. You have the right to confidentiality and the right to consent to disclosure in accordance with ORS 107.154, ORS 179.505, ORS 179.507, ORS 192.515, ORS 192.507, 42 CFR, part 2 and 45 CFR Part 205.50;

8. You have the right to 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:
   - Under age 18 and lawfully married;
   - Age 16 or older and legally emancipated by the court; or
   - Age 14 or older for outpatient services only

9. You have the right to Inspect your service record in accordance ORS 179.505; Individuals have the right to access copies of their records within 10 working days upon written request;

10. You have the right to refuse participation in experimentation;

11. You have the right to receive medication specific to your diagnosed clinical needs, including medications used to treat opioid dependence;

12. You have the right to receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;

13. You have the right to be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;

14. You have the right to have religious freedom;

15. You have the right to be free from seclusion and restraint;

16. You have the right to be informed from the start of services, and periodically thereafter, of the rights guaranteed by this rule;

INDIVIDUAL RIGHTS (Continued)

17. You have the right to be informed of the policies and procedures, service agreement and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented;

18. You have the right to have family and guardian involvement in service planning and delivery;

19. You have the right to have an opportunity to make a declaration for mental health treatment when legally an adult;

20. You have the right to file grievances, including appealing decisions resulting from the grievance;

21. You have the right to exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules

22. You have the right to exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority

23. You have the right to exercise all rights described in this rule without any form of reprisal or punishment.

24. You have the right to refuse treatment (unless court ordered);

Register to Vote

Please let our staff know if you would like to register to vote. We will direct you to our Voter Registration forms.

Individual's Grievance Procedure follows:

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.

A copy of the full Grievance Procedure was given to the Individual/Individual's Guardian, along with the initial paperwork. Individual and/or the Individual's guardian can request a copy of the Grievance Procedure at any time.

_____ _____
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 <u>I have received</u> 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:

_____

_____

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