

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	\$230.00	Over 53 Minutes	\$252.00
16-37 minutes	\$139.00	Group Sessions	\$80.00 per group
38-52 minutes	\$209.00	Couples/Family Counseling	\$281.00 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:

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

1. 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;
2. Be treated with dignity and respect;
3. 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;
4. Have all services explained, including expected outcomes and possible risks;
5. 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;
6. 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.
7. Inspect their service record in accordance with ORS 179.505;
8. Refuse participation in experimentation;
9. Receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence;
10. Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
11. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
12. Have religious freedom;
13. Be free from seclusion and restraint;
14. Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;
15. 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;

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INDIVIDUAL RIGHTS (Continued)

16. Have family and guardian involvement in service planning and delivery;
17. Have an opportunity to make a declaration for mental health treatment, when legally an adult;
18. File grievances, including appealing decisions resulting from the grievance;
19. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
20. Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
21. Exercise all rights described in this rule without any form of reprisal or punishment.

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

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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:

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

Please describe any other symptoms that you have been experiencing:
