FAMILY BEHAVIORAL
HEALTH NETWORK, LLC

221 W. Main / PO Box 36
Medford, OR 97501
541-821-9559

Please complete the following questionnaire. This information will be discussed more thoroughly in session, and used to help determine goals for treatment.

Patient Name: ______________________ Nickname: ______________

Date of Birth: __________ Sex: ☐ Male ☐ Female SSN: __________

Home Phone: __________ Cell Phone: __________ Work Phone: __________

Address: ______________________________

City: __________ State: ______ Zip: __________

Email: ______________________________

Is it ok to communicate through Email? ☐ Yes ☐ No Is it OK to leave phone Message? ☐ Yes ☐ No

Who will be responsible for making/keeping appointments? ______________________

Emergency Contact Name: ______________________ Number: __________

Primary Care Provider: ______________________ Dental Provider: __________

MANDATORY COMPLETION IF OHP/MEDICAID

Do you need an Interpreter? ☐ Yes ☐ No
Language Preferred: ______
Hearing Impaired? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No
Do you have Tribal Affiliation? ☐ Yes ☐ No

Does Patient Use Tobacco: ☐ Yes ☐ No
Has Patient Used Nonprescribed Drugs in past 90 Days? ☐ Yes ☐ No

Marital Status:
☐ Never Married ☐ Divorced
☐ Married ☐ Widowed
☐ Separated ☐ Single

Legal Status:
☐ None
☐ Parole
☐ Probation
☐ Unknown

Employment:
☐ Full Time
☐ Part Time
☐ Unemployed
☐ Homemaker
☐ Student Full Time
☐ Student Part Time
☐ Retired
☐ Disabled (Unable to work)
☐ Other

Highest grade completed in school? ______

Race:
☐ Alaska Native
☐ American Indian
☐ White
☐ Asian
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ Other Single Race
☐ Two or More Unspecified Races

Hispanic Ethnicity?
☐ Yes ☐ No
☐ Mexican
☐ Puerto Rican
☐ Cuban
☐ Other

Tribal Affiliation:
☐ N/A
☐ Klamath Tribes
☐ Cow Creek Band of Umpqua
☐ Coquille Indian Tribe
Confederated Tribes of
☐ Warm Springs
☐ Coos, L.Umpqua & Siuslaw
☐ Grand Ronde
☐ Siletz
☐ Umatilla
☐ Other:

Living Arrangement:
☐ Private Residence
☐ Foster Home
☐ Homeless
☐ Residential Facility
☐ Suppt Housing
☐ Alcohol/Drug Free Housing
☐ Other:

Household Income: $______

Household Income/Source:
☐ Wages/Salary
☐ Public Assistance
☐ Retirement/Pension/ SSI
☐ Other (Alimony, Child Support)
☐ Disability/SSDI
☐ None
☐ Unknown

Household Dependents:
How many people are dependent on this household income: 0-5_____ 6-17_____ 18-64_____ 65+______

Presenting Concerns:

What are the concerns that bring patient in for mental/behavioral health?

How long/how often have these behaviors been occurring?

What have you tried that works or isn't working?

What would you like to be different?

Risk Assessment:

Have you ever attempted suicide?☐ Yes ☐ No If yes, When and by What means? _____

Are you currently having thoughts to hurt yourself or someone else? ☐ Yes ☐ No

Are there weapons in your home? ☐ Yes ☐ No

Medical History:

Do you currently have any physical health concerns? _____

Please Describe your Sleep Patterns: _____

Do you take any Medications? _____

Family History:

Who lives in the home? (Names, ages and relationship) _____

Who are the significant relationships in your life? (family, spouse, friends) _____

Describe significant changes/transitions that have occurred recently. For example, divorce, moves, change in schools, death/loss, removal from parents' care: _____

Do any family members struggle with the following challenges? (Family is defined as brother, sister, parent, grandparent, aunt, or uncle.) _____

Family History Continued

Challenge	(If Yes) Relative
Learning challenges/disability:	
Depression/Bipolar Disorder:	
Alcoholism/Drug Addiction:	
Anxiety/Panic Attacks:	
Trauma:	
Suicide Attempts:	
Eating Disorders:	
Hyperactivity/ADHD:	
Psychosis/Schizophrenia:	
Other Problems:	

Cultural and Spiritual History:

What should I know about you to best work with you or your family? How important is spirituality or religion?

Do you currently engage in spiritual activities? ☐ Yes ☐ No If yes please explain:

Developmental History:

Have you been diagnosed with a disability? ☐ Yes ☐ No, If Yes Explain: _____

Education History:

What level of education have your received? _____

Are you currently attending school?______

Social and Work Functioning:

How do you feel your personal relationships are going? (Friends, Family, Professional) _____

What type of employment do you currently have? _____

Do you have any concerns about your ability in the work environment? ☐ Yes ☐ No

If yes, please describe: _____

What do you like to do for fun?______

Treatment History:

Have you worked with a therapist before? From 1-10, rate previous experiences: _____

Name(s) of previous therapist(s): _____

What Helped? _____

What Didn't?______

Have you seen a psychiatrist in the past? ☐ Yes ☐ No Currently? ☐ Yes ☐ No

Current Medications? ☐ Yes ☐ No If Yes, Which Ones? ____________________

Has you been hospitalized for emotional, psychological or substance use issues? ☐ Yes ☐ No

If yes, when and for how long: ____________________

Location/Facility name: ____________________

Substance Use and/or Problems Gambling:

Have use of drugs, alcohol or gambling impacted your current functioning? ☐ Yes ☐ No

If yes please explain:______

Other Information that you consider relevant: _____

Thank you for taking the time to fill out these forms completely. This information helps me to learn more about you so that we may work together more effectively.

NAME: ________________________

Adverse Childhood Experience (ACE) Questionnaire

During the patients first 18 years of life:

1. Did a parent or other adult in the household often … Swear at, insult, put down, or humiliate client? or Act in a way that made them afraid that they might be physically hurt?
   ☐ Yes ☐ No

2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? ☐ Yes ☐ No

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you? ☐ Yes ☐ No

4. Did you often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? ☐ Yes ☐ No

5. Did you often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? ☐ Yes ☐ No

6. Were your parents ever separated or divorced? ☐ Yes ☐ No

7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   ☐ Yes ☐ No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ☐ Yes ☐ No

9. Was a household member depressed or mentally ill or did a household member attempt suicide? ☐ Yes ☐ No

10. Did a household member go to prison? ☐ Yes ☐ No

Now Add your Yes's______

NAME: ___________________

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals: 12 oz. beer 5 oz. wine 1.5 oz. liquor(one shot)

1. How often do you have a drink containing alcohol?	Never ☐	Monthly or less ☐	2 - 4 times a month ☐	2 - 3 times a week ☐	4 or more times a week ☐
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2 ☐	3 or 4 ☐	5 or 6 ☐	7 - 9 ☐	10 or more ☐
3. How often do you have six or more drinks on one occasion?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
9. Have you or someone else been injured because of your drinking?	No ☐		Yes, but not in the last year ☐		Yes, in the last year ☐
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No ☐		Yes, but not in the last year ☐		Yes, in the last year ☐
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐Never ☐Currently ☐In the past

NAME: ___________________________

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Which of the following drugs have you used in the past year?

- ☐ methamphetamines (speed, crystal)
- ☐ cannabis (marijuana, pot)
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ tranquilizers (valium)
- ☐ cocaine
- ☐ narcotics (heroin, oxycodone, methadone, etc.)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ other ______________________________

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No ☐	Yes ☐
2. Do you abuse more than one drug at a time?	No ☐	Yes ☐
3. Are you unable to stop using drugs when you want to?	No ☐	Yes ☐
4. Have you ever had blackouts or flashbacks as a result of drug use?	No ☐	Yes ☐
5. Do you ever feel bad or guilty about your drug use?	No ☐	Yes ☐
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No ☐	Yes ☐
7. Have you neglected your family because of your use of drugs?	No ☐	Yes ☐
8. Have you engaged in illegal activities in order to obtain drugs?	No ☐	Yes ☐
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No ☐	Yes ☐
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No ☐	Yes ☐
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

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Policies for Outpatient Services

Most individuals come to therapy due to concerns or problems they are having in their lives. With the clinicians guidance the person or family begins a process of looking at these issues in a new way.

Appointments:
Your appointment time is specifically reserved for you. Generally, sessions run between 45-55 minutes long. There may be times when it is necessary to cancel an appointment. Twenty-four (24) hours' notice is required to cancel and appointment without financial penalty. A $25 fee will be charged for any missed session that you fail to cancel within 24 hours. If initial assessment or more than 2 appointments are missed without advance notice, services may be concluded.

Payments:
The fee rate will be agreed upon prior to providing services. Clinicians working within FBHN will provide a 15-minute phone consultation with the interested individual or family to discuss treatment options.

Insurance Rates:

Initial Assessment (60-90 Minutes):	$250.00
Treatment Planning (30-60 Minutes):	$200.00
Individual Therapy (55-60 Minutes):	$200.00
Family Therapy (55-60 Minutes):	$225.00
Interactive Therapy (Per Occurrence):	$25.00
Group Therapy (60 Minutes):	$75.00
Case Management (15 Minutes):	$50.00

Billing insurance does require additional work and time to process, so we offer a discounted rate of $150.00 per therapy session for those who choose to pay out of pocket. *Payment is expected at the beginning of each session in form of cash or check.*

There may be a charge for other services, including consultation with other professionals, preparation of reports or correspondence, and phone calls lasting over 10 minutes. We will inform you of all these charges before they occur.

We currently are contracted to bill several insurance companies. However, if your provider is not part of your network, please contact the insurance company and ask if they "reimburse for out-of-network providers." They will be able to tell you the reimbursement rate and process. If this applies, you will pay me directly for the session and we will email you a monthly superbill (receipt/claim form) to be turned into your insurance company.

We highly recommend that you check your insurance coverage, limits, deductibles, and copays. We will not attempt to keep track of your deductibles or benefit limitations and you are responsible for paying any denied claims in full. If you use your insurance, then we must send the insurance company a psychiatric diagnosis and often other information they require for authorization. Sometimes we are required to provide additional information such as treatment plans or summaries.

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for

a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Although we do provide therapy services for families, **We are NOT custody or visitation evaluator and will not make any recommendations or attend court hearings pertaining to those matters.** Should we ever be subpoenaed, we will charge a professional consultation fee of $250/per hour that is not billable through your insurance. Services such as chart reviews, phone calls, report writing, speaking to lawyers, attending and waiting for any court hearings, etc. will be part of this consultation fee.

Therapists have the right to seek legal recourse to collect unpaid balances. In pursuing these measures, we will only disclose biographical information and the amount owed, in order to ensure confidentiality.

How To Reach Us:
You can leave messages for us on the confidential voicemail at (541) 821-9559. Your call will be returned within 48 hours. If you text us, we will use text to respond to you about clarifying an appointment or time when we may speak by phone. Please do not use email as the primary form of communication as it is often not secure.

Emergencies:
If experiencing a mental health emergency and we are unable to reply to your call quickly, please call Jackson County Mental Health crisis services at (541) 774-8201; the Jackson County Help Line at 541-779-4357; or 9-1-1 for a life-threatening emergency. Also, you may go to the nearest hospital emergency room. Please notify me immediately should you take any of these actions. Should we be away from an extended period of time or in a place unreachable by my cell phone company, we will provide you the name and number of colleague who will be covering urgent calls for me in my absence.

Termination:
When you or FBHN provider decide that it is time to terminate treatment, we will plan for at least one termination session. Abrupt departures from therapy are counterproductive and may be harmful, especially for children and youth. When attendance becomes difficult, we will explore whether closing services at that time is appropriate. Often when symptoms are less stressful, appointments are less needed and missed. Please be aware that that services may be closed if 2 or more appointments are cancelled within a 2-month period. You will receive a letter to inform you when closing of services occur. If you do not attend the first 3 scheduled appointments without 24 Hour advance notice services will be closed.

Your Responsibilities:
- To keep all scheduled appointments and to contact us at least 24 hours in advance to cancel or reschedule or $25 fee with be charged at following session.
- To attend all sessions alcohol and drug free.
- To make all payments at start of each session or within 30 days of bill receipt.
- To be active in the treatment process.

Disclosure Statement Acknowledgment:
This copy is yours to keep. Please take it home with you; you may want to read it again. If you have any questions or concerns regarding the services received, please feel free to ask us at anytime. For documentation of records, please sign and date the Professional Disclosure Statement Acknowledgement form.

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Insurance Billing

Using your Insurance: I am willing to directly bill your insurance company if it is one by whom I have been credentialed and have been placed on their approved provider panel. Co-Payments are due within 30 days of Billing. Co-insurance is billed after the insurance company has paid their portion and is due when billed. You are responsible for any amount that goes toward your deductible. You will be billed for any amount that your insurance company does not pay. These fees stated are for therapy only, and do not include services for writing reports, letters or for testifying in legal matters. I will need a copy of both sides of your insurance card at or before our first meeting and updated photocopy each time you renew or change insurance companies.	
Initial If Agree:	
_____	Permission to release Payment and Personal Health Information (PHI) for billing purposes and Assignment of benefits:
_____	I request payment under my medical insurance program to made directly to Family Behavioral Health Network, LLC for all services furnished to me or my family and accept the financial responsibility for all deductible amounts, co-pays, and other insurance amounts.
_____	I authorize Family Behavioral Health Network, LLC or their billing agent to provide/disclose any required PHI to my insurance company to facilitate the use of my benefits. Routinely this will include dates of service and diagnostic codes, but may include more detailed information about your progress in treatment.

Signature of insured:	Date:
Printed Name of Minor, If Applicable	Date:

Insurance Company:_________________________________

Group Number:_____________________ Member Number: ___________________

Benefit Subscriber:___________________ Benefit Subscribe Date of Birth:____________

Please bring card at beginning of services

FAMILY BEHAVIORAL
HEALTH NETWORK, LLC

Family Behavioral Health Network, LLC
221 W. Main ~ Medford OR 97501
P: 541-821-9559 ~ F: 541-702-1236

Authorization to Release Information to Primary Care Provider

Family Behavioral Health Network, LLC has a strong commitment to Integrated Medical Care.
This consent acknowledges that health care collaboration may be part of treatment.

Name(Patient): ______________________ Date of Birth: ___________

I authorize Family Behavioral Health Network, LLC and to disclose information to and obtain information from: Primary Care Provider (Doctor):____ ___________

Clinic/Agency: _____________

Address: ___________

Phone: _______________ Fax: __________________

Description of information to be disclosed: _**All medical records, communication with medical providers and other related coordination's with mental health services.**

The purpose of this is to aid evaluation, treatment, coordination of services and/or other activities (specify): on behalf of the client. I understand that I may revoke this release at any time by submitting a written notification, but that such a request will not apply to any information exchanged prior to the date of such a notification being received by Family Behavioral Network

Unless sooner revoked, this consent expires on __________ or as otherwise indicated: __________.

____ Date: ________________
Patient Signature (If over 14)

____ Date: ________________
Provider Signature

FAMILY BEHAVIORAL
HEALTH NETWORK, LLC

Family Behavioral Health Network, LLC
221 W. Main ~ Medford OR 97501
541-821-9559

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the Oregon Board of Licensed Professional Counselors. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

As a licensee of the Oregon Board of Licensed Professional Counselors and Therapists it is my practice to adhere to the more stringent privacy requirements for disclosures with and without authorization. These requirements are found in the OBLPCT Code of Ethics, Oregon Administrative Rules and HIPAA.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing

services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law: Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Without Authorization: Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect: We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings: We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients: We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies: We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care: We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight: If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena, court order, administrative order or similar document.

Specialized Government Functions: We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health: If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety: We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Workers' Compensation: We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Research: PHI may only be disclosed after a special approval process or with your authorization.

Fundraising: We will not participate in fund raising activities.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Verbal Permission: We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Psychotherapy Notes: We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Jennifer Henderson or Richard Stubbs.

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself. . We will make every effort to contact you via mail or phone, and may need to use your email address.

- Right to a Copy of this Notice. You have the right to a copy of this notice and receive a copy via paper or electronically.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Jennifer Henderson at PO Box 36 Medford, OR 97501 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

You may also contact your Insurance company directly.

EFFECTIVE DATE: The effective date of this Notice is April 1st, 2016.

Family Behavioral Health Network, LLC
221 W. Main ~ Medford OR 97501
541-821-9559

Acknowledgement of Receipt of
Professional Disclosure Statement and Therapy Contract

Please Initial: The Following Items and Ask Questions As Needed

	I agree to enter into therapy and behavioral treatment with contracted providers of Family Behavioral Health Network, LLC.
	If I cannot attend a scheduled session, I will give 24 hours notice. If I do not give this notice, I will be required to pay $25 for the missed session. I understand that there are exceptions, and we will discuss these if needed.
	FOR PRIVATE PAY: As agreed upon, I will pay _______ in full at the beginning of each session. I understand that I am ultimately responsible for these fees, and agree to pay the balance in full at start of each session.
	I understand that Family Behavioral Health Network, LLC may engage a collection agency and/or may utilize other legal measures to recover any unpaid balances, but will give me reasonable notice before taking any such action. I also understand that if any such actions are taken, Family Behavioral Health Network, LLC will not reveal any clinical information during these procedures.
	I understand that I can I refuse services and end treatment at any time.
	I have reviewed the Professional Disclosure Statement for my assigned clinician. I have reviewed my rights and responsibilities as the individual or youth's legal guardian. I have had opportunity to ask questions for clarification.
	I have reviewed the Notice of Privacy Practices
	FOR MEDICAID (Adults Only): • I have discussed the Advanced Directive with my provider. I understand I can put this on file at any time and that it is in effect for a period of three years or until revoked. • I have discussed the Declaration for Mental Health Treatment with my provider. I understand I can put this on file at any time, and that it remains in effect until revoked.

____ Date: _______________

Patient Signature

____ Date: _______________

FBHN Provider Signature