

Youth Intake Information

Please complete the following questionnaire from the perspective of the individual who will be the **PATIENT**. 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 _____ Number: _____

Primary Care Provider: _____ Dental Provider: _____

Treatment for youth under 14 will require consent by their legal guardian

Are you the legal guardian? Yes No If No, who is? _____

MANDATORY COMPLETION IF OHP/MEDICAID			
Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Patient Use Tobacco: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Preferred: _____	Do you have Tribal Affiliation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Patient Used Nonprescribed Drugs in past 90 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing Impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single	Legal Status: <input type="checkbox"/> None <input type="checkbox"/> Parole <input type="checkbox"/> Probation <input type="checkbox"/> Unknown	Employment: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student Full Time <input type="checkbox"/> Student Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled (Unable to work) <input type="checkbox"/> Other
Race: <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other Single Race <input type="checkbox"/> Two or More Unspecified Races	Hispanic Ethnicity? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other	Tribal Affiliation: <input type="checkbox"/> N/A <input type="checkbox"/> Klamath Tribes <input type="checkbox"/> Cow Creek Band of Umpqua <input type="checkbox"/> Coquille Indian Tribe Confederated Tribes of <input type="checkbox"/> Warm Springs <input type="checkbox"/> Coos, L.Umpqua & Siuslaw <input type="checkbox"/> Grand Ronde <input type="checkbox"/> Siletz <input type="checkbox"/> Umatilla <input type="checkbox"/> Other:	Highest grade completed in school? _____ Living Arrangement: <input type="checkbox"/> Private Residence <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Residential Facility <input type="checkbox"/> Suppt Housing <input type="checkbox"/> Alcohol/Drug Free Housing <input type="checkbox"/> Other:
Household Income: \$ _____	Household Income/Source: <input type="checkbox"/> Wages/Salary <input type="checkbox"/> Public Assistance <input type="checkbox"/> Retirement/Pension/ SSI	<input type="checkbox"/> Other (Alimony, Child Support) <input type="checkbox"/> Disability/SSDI <input type="checkbox"/> None <input type="checkbox"/> 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 or symptoms been occurring?

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

What would you like to be different?

Risk Assessment:

Are you, or do you have concerns patient may hurt themselves or someone else? Yes No

If Yes, Please Describe:

Are there weapons in your home? Yes No

Medical History:

Does patient have any chronic health conditions?

Please describe patients sleep patterns:

Does the patient take medications?

Family History:

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

Who are the supportive individuals in the patient's life? (coach, caseworker, family, sitter)

Describe significant changes/transitions in the patient's life and the age they that they occurred. For example, divorce, moves, change in schools, death/loss, removal from parents' care:

If patients is youth and parents are divorced or separated, what are the current custody and visitation arrangements?

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

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:	_____

Treatment History:

Has patient been in therapy before? If yes, From 1-10, rate previous experiences: _____

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

What Helped? _____

What Didn't? _____

Has patient seen a psychiatrist in the past? Yes No Currently? Yes No

Current Medications? Yes No If Yes, Which Ones?

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

If yes, when and for how long: _____

Location/Facility name: _____

Developmental History:

Were there any complications with the patients pregnancy and delivery as a child? Yes No, If Yes Explain:

If known, describe patient as a baby:

Have you or anyone else had concerns about patients social development? Yes No If yes, explain:

Have you or anyone else had concerns about the intellectual or academic functioning of patient? Yes No

If yes, explain:

Social, School Functioning:

Please describe how patient interacts with others at school:

Do you have any concerns about patients functioning in the school environment? Yes No

What School does the patient attend?

Teacher Name/Grade:

Please describe patients school performance:

Has patient ever been diagnosed with a learning disability/problem? Does patient access special education services/IEP/504

Yes No

Cultural and Spiritual History:

Does patient participate in any extracurricular activities?

What should I know about patient and family to best work with you?

How important is spirituality or religion?

Does your child or family currently engage in spiritual activities? Yes !!!! No !!!! If yes please explain:

Substance Use and/or Problems Gambling:

Is or has youth used drugs, alcohol or gambling? Yes No

If yes please explain:

Behavior Management:

Describe discipline in your home:

What are your expectations of your child?

What areas does your child excel in?

What do you enjoy about parenting?

Adverse Childhood Experience (ACE) Questionnaire

During the first 18 years of life:

Did a parent or other adult in the household often ... Swear, insult, put you/child down, humiliate you/them or Act in a way that made you/child afraid that he/she might be physically hurt?

Yes No

Did a parent or other adult in the household often ... Push, grab, slap, or throw something at you/child? or Ever hit!you/child so hard that they had marks or were injured?

Yes No

Did an adult or person at least 5 years older than you/child ever... Touch or fondle you/child or have you/them touch!their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you/them?

Yes No

Did you often feel that ... No one in your/child's family loved you/them or thought you/they were important or special?or Your/child's family didn't look out for each other, feel close to each other, or support each other?

Yes No

Did you/child often feel that ... You/they didn't have enough to eat, had to wear dirty clothes, and had no one to!protect! you? or parents/caregivers were too drunk or high to take care of you or take you/them to the doctor if needed it?

Yes No

Were your/child's parents ever separated or divorced?

Yes No

Was your/child's 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

Did you/child live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No

Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No

Did a household member go to prison?

Yes No

Total Yes's: _____



Patient Name: _____

Date: _____

Person Completing: _____

LAGGING SKILLS

- Difficulty handling transitions, shifting from one mindset or task to another (shifting cognitive set)
- Difficulty doing things in a logical sequence or prescribed order
- Difficulty persisting on challenging or tedious tasks
- Poor sense of time
- Difficulty reflecting on multiple thoughts or ideas simultaneously
- Difficulty maintaining focus for goal-directed problem-solving
- Difficulty considering the likely outcomes or consequences of actions (impulsive)
- Difficulty considering a range of solutions to a problem
- Difficulty expressing concerns, needs, or thoughts in words
- Difficulty understanding what is being said
- Difficulty managing emotional response to frustration so as to think rationally (separation of affect)
- Chronic irritability and/or anxiety significantly impede capacity for problem-solving
- Difficulty seeing the "grays"/concrete, literal, black-and-white, thinking
- Difficulty deviating from rules, routine, original plan
- Difficulty handling unpredictability, ambiguity, uncertainty, novelty
- Difficulty shifting from original idea or solution/difficulty adapting to changes in plan or new rules
- Difficulty taking into account situational factors that would suggest the need to adjust a plan of action
- Inflexible, inaccurate interpretations/cognitive distortions or biases (e.g., "Everyone's out to get me," "Nobody likes me," "You always blame me," "It's not fair," "I'm stupid")
- Difficulty attending to or accurately interpreting social cues/poor perception of social nuances
- Difficulty starting conversations, entering groups, connecting with people/lacks other basic social skills
- Difficulty seeking attention in appropriate ways
- Difficulty appreciating how his/her behavior is affecting other people
- Difficulty empathizing with others, appreciating another person's perspective or point-of-view
- Difficulty appreciating how s/he is coming across or being perceived by others

UNSOLVED PROBLEMS/ SITUATIONS THAT ARE DIFFICULT

HOME

- Waking up/getting out of bed in the morning
- Completing morning routine/getting ready for school
- Sensory hypersensitivities
- Starting or completing homework or a particular academic task
- Food quantities/choices/preferences/timing
- Time spent in front of a screen (TV, video games, computer)
- Going to/getting ready for bed at night
- Riding in car/wearing seatbelt
- Boredom
- Sibling interactions
- Cleaning room/completing household chores
- Taking medicine

SCHOOL

- Shifting from one specific task to another (specify)
- Getting started on/completing class assignment (specify)
- Interactions with a particular classmate/teacher (specify)
- Behavior in hallway/at recess/in cafeteria/on school bus/waiting in line (specify)
- Talking at appropriate times
- Specific academic tasks/demands, e.g., writing assignments (specify)
- Handling disappointment/losing at a game/not coming in first/not being first in line (specify)

OTHERS (list)

Patient Name: _____
 Person Completing: _____

Date of Birth: _____
 Date: _____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

		Never (0)	Sometimes (1)	Often (2)
1. Complains of aches/pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with a teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interest in friends	15	_____	_____	_____
16. Fights with others	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? N Y

Are there any services that you would like your child to receive for these problems? N Y

If yes, what services? _____



Family Behavioral Health Network, LLC
221 W. Main ~ Medford, OR 97501

Insurance Billing

Using your Insurance: We are willing to directly bill your insurance company if it is one by whom we have been credentialed and have been placed on their approved provider panel. Co-Payments are due at the time of each service. 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. We 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:
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	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.
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	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.
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Signature of insured:

Date:

Printed Name of Minor, If Applicable

Date:

Insurance Company: _____

Primary Insured (PI): _____ Date of Birth PI: _____

Group Number: _____ Member ID Number: _____

Please bring card at beginning of services



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 this 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:

Medical and Mental Health Treatment Coordination and Records

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 Health Network, LLC

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

Patient Signature (If over 14) Date: _____

Parent or Guardian's Signature Date: _____

Provider Signature Date: _____

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 Family Behavioral Health Network, LLC and its contracted providers.
	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.
	As agreed upon, I will pay my copays or coinsurance and that I am ultimately responsible for these fees, and agree to pay the balance in full.
	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
	<p>FOR MEDICAID (18 and Over Only):</p> <ul style="list-style-type: none"> • 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. • I have been offered an opportunity to register to vote.

_____ Date: _____
Patient Signature (if Over 14)

_____ Date: _____
Parent or Guardian's Signature

_____ Date: _____
Provider Signature

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 an appointment without financial penalty. Fee will be charged a \$25 fee for any missed session that you fail to cancel within 24 hours.

Payments:

The fee rate will be agreed upon prior to providing services. Family Behavioral Health Network, LLC will provide a 15-minute phone consultation with the interested individual or family to discuss treatment options.

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 Play Therapy (Per Occurrence):	\$25.00
Group Therapy (60 Minutes):	\$75.00
Case Management/Environmental Recommendation (15 Minutes):	\$50.00

Payment is expected no later than 10 days from the date of statement or at the beginning of each session in form of cash, check or credit card.

There may be a charge for other services, including consultation with other professionals, preparation of reports or correspondence, and phone calls lasting over 8 minutes. We will inform you of all these charges before they occur.

We are currently contracted to bill several insurance companies. However, if we are 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 us 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 evaluators 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 Me:

You can leave messages for us on our 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. You can also access us through your Patient Portal to schedule, cancel or inform me of needs.

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 for 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 in our absence.

Termination:

When you or we 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 will be charged at following session.
- To attend all sessions alcohol and drug free.
- To make all payments at start of each session or in advance.
- 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.

Complaints and Grievances:

If ever you feel that the services are not meeting needs, we welcome feedback surrounding concerns or complaints. Please discuss with your provider or contact your insurance company express concerns.



Family Behavioral Health Network, LLC
221 W. Main, Medford, OR 97501

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.

- **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.

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