503.352.0240
Fax 503.352.0242
www.nhws.us

NEW HORIZONS
WELLNESS SERVICES, LLC

9400 SW Beaverton-Hillsdale Hwy.,
Suite 210, Beaverton, Oregon 97005

Dear New Patient,

Welcome to New Horizons Wellness Services, LLC (NHWS)! We are excited to have the opportunity to assist you with your mental health care. Our therapists strive to provide the highest quality treatment using the most current and innovative therapy treatments currently available, in a professional and caring manner.

NHWS provides therapy for both children and adults. We specialize in the individualized treatment of each patient. NHWS is also a teaching clinic so on occasion students from various colleges may accompany your therapist, observe treatment and have sight of your notes. Please let me, your therapist, or our office staff know if this is a concern for you.

Enclosed is the New Patient Intake Packet. Please read the information carefully, fill out all the documents, and return to us within **7 days** of receiving this packet. **It is very important to understand that if your intake packet is not received within this time frame your appointment will be cancelled and you will need to reschedule.** Please note that payment is due at the time of the appointment. We accept cash, checks, Visa, MasterCard, and Discover. Checks should be made payable to New Horizon Wellness Services. If you choose to pay by credit card, please have your driver's license and credit card with you at the time of the appointment.

NHWS is an in-network provider with Cigna, Aetna, United Behavioral Health, Providence Health Plans, Family Care, MHN, Value Options, and Pacific Source, and files out-of- network insurance claims with Blue Cross Blue Shield (BCBS) and other insurance companies. It is your responsibility to determine the proper coverage for mental health services and to contact your insurance company regarding your in-network or out-of-network benefits, deductible and/or copays prior to the appointment. If we are out-of-network with your insurance plan, you will need to pay in-full for each appointment at the time services are rendered and receive reimbursement from your insurance company in accordance with the terms of your contract with them. Once we receive your insurance information, we can schedule your initial appointment. The initial evaluation will last approximately one hour. Our office will then schedule a follow-up appointment to discuss the initial assessment and treatment options with you.

With kind regards,

Patrick Ethel-King
Owner and Director, NEW HORIZONS WELLNESS SERVICES, LLC

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Outpatient Service Contract

Welcome and thank you for the opportunity for New Horizons Wellness Services, LLC (NHWS) and our group of providers to offer our professional help to you. This document contains important information about the professional services you will receive and our business policies. **Please read it carefully and ask for clarification when needed. Keep one copy of this document for your records and return an initialed and signed copy to our office to be kept in your patient file.**

Psychological Services

We make every effort to provide you with the highest quality mental health services available. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the provider and the patient, and the particular problem he/she brings forward. There are many different methods that may be used to deal with the problems that you hope to have addressed. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things that are talked about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for individuals who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Psychotherapy may be provided by Dr, Ethel-King or providers employed by New Horizons Wellness Services, LLC. From time to time interns may provide services in association with New Horizons Wellness Services, LLC, under the supervision of a licensed psychologist.

Your first few appointments will involve an initial assessment of your needs. By the end of the initial assessment, your therapist will be able to offer you some first impressions of what the therapy services will include and a treatment plan will follow, if you decide to continue with therapy. You should evaluate this information and determine if you feel comfortable working with the therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about your therapist's procedures, you should discuss them as they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion. _____ (Initials)

Treatment Sessions

Therapy sessions are 45 minutes. The first appointment is a 60 minute sessions (initial intake). Times given are face to face with the therapist. Sessions end promptly at the end of the allotted time to give your therapist time to complete session notes. Most clients will meet with their therapist for a 45 minute session every other week. The frequency of sessions will be a joint decision. _____ (Initials)

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Please make all checks payable to New Horizons Wellness Services. Please note, there will be a $45.00 charge for all returned checks. The credit card receipt provided at the time of services is your receipt. Statements are provided upon request only. _____ (Initials)

No Shows

Appointments that are not cancelled are considered a No Show. **If you fail to keep a scheduled appointment and have not cancelled you will be charged the full rate of the scheduled therapy session.** It is important to note that insurance companies do not provide reimbursement for missed appointments. _____ (Initials)

Cancellations and Rescheduling

Your appointment time is reserved exclusively for you. Please help us serve you better by keeping scheduled appointments. **The full fee is charged for appointments cancelled less than 24 hours in advance.** It is important to note that insurance companies do not provide reimbursement for missed appointments. _____ (Initials)

Late Arrival

Unless otherwise indicated, individual therapy appointments are 45 minutes. If you arrive late for a scheduled appointment, the appointment will still end on time. Please be advised that you will be charged for the full amount of time that was allotted for the appointment. _____ (Initials)

Termination Session

Please note it is always recommended that you schedule a final session to wrap up services once you have achieved your goals. This final session is very important for you to have closure on the process, discuss additional goals, and celebrate progress! Please talk to your therapist when you feel ready to schedule this session. _____(Initials)

Confidentiality & Patient Rights

In general, the privacy of all communication between a patient and a psychologist is protected by law. In most situations, we can only release information about your treatment to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that child, elderly person, or disabled person is being abused, I may be required to file a report with the appropriate state agency.

If I believe that you are threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about the potential problems, it is important that we discuss any questions or concerns that you may have at your appointment. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. _____ (Initials)

Professional Records

The laws and standards of our profession request us to keep treatment records. You are entitled to receive a copy of your records, or a summary can be prepared for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them with your therapist so that he/she can discuss the content. You will be charged an appropriate fee for any professional time spent preparing, copying, and mailing your records. Payment is required before records are sent or picked up. Record requests are typically able to be handled within 2 weeks of the request.

NOTE: Please be advised, in the event we receive a subpoena or request for records regarding your records, our office staff will contact you to obtain your written consent. _____ (Initials)

Contacting Your Therapist

Please note that telephone calls are answered between **9:00 am - Noon** and **1:00 - 5:00 pm**, Monday through Friday. We are generally closed on Fridays during the summer months. Messages may be left on our voice mail system. We will make every effort to return your call on the same day you make it, or at least within 24 hours, with the exception of weekends and holidays. **Electronic communication, (email), presents a potential risk to patient confidentiality.** While patients may find this a convenient way to communicate they must be aware of the risks. We will respond should you choose to email us regarding non-clinical issues such as appointment scheduling. **Please note we will not engage in "therapy" nor respond to casual "chats" via email.** Information exchanged by fax/email will become a part of the clinical record. _____(Initials)

In Case of an Emergency

We do not provide emergency services, and thus you should exercise one of the following options in an emergency: contact your psychiatrist or primary care physician, go to the nearest hospital emergency room and ask to speak with the psychiatrist on call, and/or follow your insurance carrier's emergency procedures. _____(Initials)

RECORDING AT ANY TIME BY ANY PARTY IS NOT ALLOWED WITHOUT PERMISSION

Recording of conversations and communications without consent apply to, but not limited to, in-person counseling/consultations, phone calls, video communication (Skype, Facetime, etc.).
_____(Initials)

Clinic and Waiting Room Manners

The care and safety of children that accompany you to your session are your responsibility. We ask that you please monitor your child(ren) in the waiting room and respect the property of NHWS and the other families in the reception area. **At times seating, can be limited in the waiting room, please allow adults to sit down.** We make every effort to keep our waiting room clean and tidy. If you bring snacks and/or drinks into the waiting room, please keep the area clean of any spills. We greatly appreciate the use of lidded cups. Thank you in advance for your courtesy. _____ (Initials)

Insurance Reimbursement:

New Horizons Wellness Services (NHWS) is an in-network provider with United Behavioral Health (UBH), Aetna, Cigna, Moda, Pacific Source, Value Options, MHN, and FamilyCare and files out-of-network insurance claims with Blue Cross Blue Shield (BCBS). Please notify us if your insurance company is not listed and we will research our ability to file your claims and provide treatment under your insurance plan.

Many insurance plans place significant limits on your choice of mental health provider, on the amount of services that you can receive, and on the amount of money that can be charged for and spent on services. You should carefully read the section in your insurance coverage book that describes mental health services. If you have questions about the coverage, call your plan administrator.

You should be aware that your contact with your health insurance company requires that we provide it with information relevant to the services that we provide you, including clinical diagnosis. If we are required to provide additional clinical information we make every effort to release only the information about you that is necessary for the purposes requested.

You are required to pay your annual in-network deductible at the beginning of your plan's calendar year. After your deductible has been satisfied, you're responsible for the co-pay or co-insurance amount set by your insurance carrier. Any non-covered services are your financial responsibility. Co-payments, co-insurance, non-covered services and/or deductibles are your responsibility and are payable at the time of service.

In the event that payment for a performed service is denied by the insurance carrier, it is your responsibility to pursue action with your insurance carrier, as the policy is a legal contract between you and the insurance company.

Please note that you always have the right to pay for services privately without seeking insurance reimbursement in order to avoid the problems described above. _____(Initials)

Medicaid:

FamilyCare participants are exempt from our insurance reimbursement policy. The requirements in order to be accepted and maintained will be mandatory attendance and cancellations with at least 24-hour notice. Two (2) no shows will result in the discontinuation of services. _____(Initials)

For other Carriers, there is no insurance coverage:

If a patient has insurance carriers other than United Behavioral Health (UBH), Aetna, Cigna, Moda, Pacific Source, Value Options, MHN, FamilyCare or has no insurance coverage, they are responsible for all charges incurred at the time of services. Co-payments, Co-insurance, non-covered services and/or deductibles are the responsibility of the patient and are payable at the time of service.
_____(Initials)

BY SIGNING THIS DOCUMENT, I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE. I MUST PROVIDE A PHOTO COPY OF MY INSURANCE CARD ANNUALLY AND ANY TIME I CHANGE INSURANCE PLANS. IT IS MY RESPONSIBILITY TO NOTIFY NHWS OF ANY CHANGES. I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE PLAN.
_____ (Initials)

Your signature below validates your initials on each of the clinic polices described above. We appreciate your time and effort in completing this form. Accurate patient documentation is necessary for NHWS to protect our patients' rights.

_____ _____
Patient's Name (print) Patient's Signature

_____
Date

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HIPAA 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 carefully.**

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for services
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your written request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us to not use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list of (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the first page of this document.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, DC 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filling a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situation described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

OUR USES AND DISCLOSURES

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMANTION?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situation such as:

- Preventing disease
- Helping with product recall
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal law requires it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address worker's compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions, such as military, national security, and presidential protective services.

Respond to lawsuit and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy of security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- Will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

EFFECTIVE DATE: NOVEMBER 1, 2016

_____ _____

Signature of Patient or Personal Representative Date

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Patient Registration Form

Client Name: _____ DOB: _____ □Male □Female

Address _____ City, State: _____ Zip: _____

Home#: _____ Cell#: _____ Work #:_____

Best number to reach you: □Home □Cell □Office Email:_____

Parent/Guardian (If minor): Mother _____ Father _____

Phone number (If different): _____

Address (If different than client): _____

Parents are: □ Married □ Separated □Divorced Parenting Plan? □ Yes □ No

How did you hear about us? □Website* □ Flyer □School* □Friend* □Insurance*

PHYSICIAN'S INFORMATION

Primary Physician: _____ Phone #:_____

Fax #_____ Address: _____

Referring Physician: _____ Phone #: _____

Fax #: _____ Address: _____

INSURANCE INFORMATION

Insurance Company: _____ Phone: _____

Name of Policy Holder: _____ Policy Holder DOB: _____ □ M □ F

Relationship to Insured: _____ Policy Holder's Employer:_____

ID#:_____ Group#: _____

Assignment and Release: I hereby authorize New Horizons Wellness Services, LLC to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to New Horizons Wellness Services, LLC and I am financially responsible for any unpaid balance. I declare the foregoing information is true and correct.

_____ _____
Print Name Date

_____
Responsible Party

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ADULT CLIENT INTAKE QUESTIONNAIRE

Name: _____ Today's Date: _____
First Middle Last

Gender: M [ ] F [ ] Age: _____ Ethnicity: _____ Birth Date: _____

Address: _____ City, State, Zip: _____

Telephone(s): _____ _____ _____
(home) (cell) (work)

e-mail 1: _____ e-mail 2: _____

May we leave messages for you? [ ] On home phone [ ] On work phone [ ] Other [ ] No

[ ] I live alone [ ] Others living in the home [ ] Significant others outside the home

List the people who live in your household

Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:

Emergency contact: _____ Phone: _____

Relationship: _____

Referred by: _____

	Education	Occupation	Employer
Self			
Partner			

STRENGTHS & ISSUES

Describe the issues or problem(s) that brought you here today:

When did these problems begin?

What is going well in your life?

Hobbies & Interests?

How are your family relationships (current family and family of origin)?

Do you have any health issues or injuries?

What are your goals for this visit?

Is there any other information that may be helpful (for example, issues of diversity, spirituality or significant recent events)?

Check any of the symptoms that you are having:			
Depression		Feeling hopeless	
Extreme sadness		Feeling tearful	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight changes	
Feeling of extreme happiness		Change in sexual interest or function	
Trouble performing your job		Problems getting along with friends or family	
Lack of enjoyment of usual activities		Feeling stressed	
Self-esteem problems		Easily irritated	
Perfectionism		Feeling guilty	
Obsessions or compulsions		Feeling nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Muscle tension	
Problems with anger		Acting violently	
Thoughts or hurting yourself or others		Thoughts of killing yourself or others	

HAVE YOU EVER BEEN IN COUNSELING BEFORE Yes [ ] No [ ]

If you have been in counseling before, please describe it below. Start with the most recent time first.

A. Date(s):	
Provider Name:	
Explain what happened:	

B. Date(s):	
Provider Name:	
Explain what happened:	

C. Date(s):	
Provider Name:	
Explain what happened:	

MEDICAL INFORMATION

Have you seen a doctor within the last year	Yes [ ]	No [ ]
Why have you seen a doctor?		
Who is your doctor? Location:	Phone:	
Are you taking any medications, prescription or other-the-counter? Please describe:	Yes [ ]	No [ ]

Medications	Dosages
1.	
2.	
3.	
4.	

SUBSTANCE USE HISTORY

Do you use/have you used tobacco (any form)?	Current [ ]	Past [ ]	No [ ]
Do you use/have you used alcohol?	Current [ ]	Past [ ]	No [ ]
Do you use/have you used caffeine (any form, including cola drinks)?	Current [ ]	Past [ ]	No [ ]
Do you use/have you used other mind-altering substances (drugs)? If yes, please describe:	Current [ ]	Past [ ]	No [ ]
1.	Current [ ]	Past [ ]	No [ ]
2.	Current [ ]	Past [ ]	No [ ]
3.	Current [ ]	Past [ ]	No [ ]
4.	Current [ ]	Past [ ]	No [ ]

IF THERE IS OTHER INFORMATION THAT YOU THINK IS IMPORTANT, PLEASE ATTACH ADDITIONAL SHEETS

_____ _____

Patient's Name (print) Patient's Signature

_____

Date

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INSURANCE BENEFIT CHECK FORM
(Keep for Your Records)

Patient's Name: _____ Check Date: _____

Date of Birth: _____

Insurance Information

Primary Insurance: _____

Policy Holder Name: _____

Member ID: _____

Group Number: _____

Questions for Your Insurance Company

DEDUCTIBLES: what you pay each year before you receive coverage

How much is your family in network deductible? $_____

How much has been met to date? $_____

How much is my in network deductible? $_____

How much has been met to date? $_____

How much is your family out of network deductible? $_____

How much has been met to date? $_____

How much is my out of network deductible? $_____

How much has been met to date? $_____

MAXIMUM OUT OF POCKET: when your insurance will pay 100% of your treatment costs

How much is my maximum out of pocket? $_____

How much has been met to date? $_____

Visits: the number of sessions

How many mental health counseling visits are available? **#_____**

COPAYMENTS or COINSURANCE
How much is my co-pay or coinsurance per visit? **$_____**

REQUIREMENTS

Do I need a doctor's referral? YES / NO

Do I need a prior authorization? YES / NO

COVERAGE DETAILS

Does my policy cover mental health services? YES / NO

Insurance companies always indicate that stated benefits are never a guarantee of payment. That said, if your insurance company denies payment for services that were quoted to you as covered using the questions above, please contact your insurance company directly.

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Authorization To Use And Disclose Protected Health Information

I hereby authorize New Horizons Wellness Services to use and disclose and/or receive specific health information described below regarding:

Patient Name: _____ Date of Birth: _____

To/From: _____(Name of recipient)

Address: _____ City/State: _____

Zip Code: _____ Phone#: _____ Fax#: _____

for the purpose of: _____ Continuation of Care/Treatment _____ Diagnostic/Evaluation

_____ Other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ Entire Medical Chart
_____ Medical Testing Information
_____ Medical Treatment Information (summary)
_____ Academic Records
_____ Entire Mental Health Chart
_____ Mental Health Testing Information
_____ Mental Health Treatment Information (summary)

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDs information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to **Kiri Tomasco** at New Horizons Wellness Services, LLC ~ 9400 SW Beaverton Hillsdale Hwy., Ste. 210 ~ Beaverton, OR 97005 and state that you are revoking this authorization. Unless revoked earlier, this consent will expire **90** days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. I have read this information and I understand it. Unless revoked, this authorization expires _____ (insert either applicable date or event).

Responsible Party Signature: _____ Date: _____