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 Family,

Welcome to New Horizons Wellness Services, LLC (NHWS)! We are excited to have the opportunity to assist your child in their 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 helping children develop skills to improve their social interactions and peer relationships. NHWS is also a teaching clinic so on occasion students from various colleges may accompany your child's group facilitator, observe group sessions and have sight of their notes. Please let me, the group facilitator, or our office staff know if this is a concern for you.

Enclosed is the Social Skills Intake Packet. Please read the information carefully, fill out all the documents, and return within **7 days** from the date that your child's intake appointment was scheduled. **It is very important to understand that if the packet is not received within this time frame your child's appointment will be cancelled and you will need to reschedule.** The initial intake appointment will last approximately one hour.

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 mental health 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 other insurance companies. It is your responsibility to determine the proper coverage for group therapy 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 group session at the time services are rendered and receive reimbursement from your insurance company in accordance with the terms of your contract with them.

With kind regards,

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

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Clinic Policies

Please read the following policies. Keep one copy of this document for your records and return a signed and initialed copy to the office to be kept in your patient file.

Group Sessions

Group sessions are one hour (60 minutes). The last 5-10 minute of each group session is generally dedicated to discussing the treatment session with the parent. _____ (Initials)

Payments and Billing

Payment for service is due at the time services are rendered. The individual who brings the child to group is responsible for payment of the group therapy session. Please make all checks payable to New Horizons Wellness Services. Please note, there will be a $40.00 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)

Participation

In order for your child to reach his/her established treatment goals, it is important that he/she attends every group session. **When you agree to have your child participate in group, he/she is given a spot in the group, and we are unable to offer that spot to anyone else. Therefore, if your child misses a group session, you will be responsible for full payment.** Missed group sessions cannot be billed to insurance. _____ (Initials)

Financial Agreement

Insurance Policy

New Horizons Wellness Services (NHWS) is an in-network mental health 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 other insurance companies. We maintain a contractual agreement with Kaiser, which allow us to file insurance claims with them. 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.

Patients are required to pay their annual out-of-network or in-network deductible at the beginning of their plan's calendar year. After the patient's out-of-network or in-network deductible had been satisfied, the patient is responsible for the co-pay or co-insurance amount set by their insurance carrier. Any non-covered services are the financial responsibility of the patient. Co-payments, co-insurance, non-covered services and/or deductibles are the responsibility of the patient 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 the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the patient and the insurance company. _____ (Initials)

Medicaid

FamilyCare participants are exempt from our insurance policy. The requirements in order to be accepted and participate in group therapy will be mandatory attendance. Two (2) cancellation and/or no shows will result in the discontinuation of participation in group. _____ (Initials)

Visit Limits

Visit limits are set by your insurance carrier. If your insurance policy has visit caps or limited visits, it is your responsibility to track these visits as they occur. If you have participated in any therapy services with another provider during the insurance year, then you will need to include those visits. NHWS will do our best to keep track of these visits, but it is the patient's responsibility to manage the visits overall. This is especially important if you have received additional services such as speech therapy, physical therapy, etc. _____ (Initials)

Patient Release for Interns and Volunteers

NHWS is a teaching clinic so on occasion student interns from various colleges may accompany the group facilitator, observe group sessions, and have sight of patients notes. A background check through each respective institution is conducted for each student intern. NHWS periodically allows volunteers to assist in the clinic. They may be in the treatment area with your child under the supervision of the group facilitator. Each volunteer has HIPAA privacy instructions. Volunteers are in place to learn, to assist the group facilitator and to work for the benefit of patient care. Volunteers are not employees of NHWS and cannot assist you with billing, scheduling, medical or insurance information.

By signing, I understand that my child's group sessions, group notes and/or invoices may be seen by student interns in training to become Doctoral or Masters level therapists. I understand that the student interns and/or volunteers may be involved in my child's treatment. _____ (Initials)

Release of Information for children attending group who are older than 18?

I understand that it is necessary for NHWS receive either proof of guardianship or permission from the patient to share any details regarding evaluation or treatment (orally or through written documentation) with parents or other family members. This is in reference to legal policy regarding privacy laws/confidentiality, in addition to the privacy polices of NHWS. If legal guardianship is not provided, the patient must fill out and sign an Authorization To Use and Disclose Protected Health Information form prior to any discussion of services with those other that the patient (verbal consent will not be acceptable).
_____ (Initials)

Contacting the Group Facilitator

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 you may find this a convenient way to communicate you 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 your child's clinical record. _____ (Initials)

BY SIGNING THIS DOCUMENT, I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE. I MUST PROVIDE A COPY OF MY/MY CHILD'S 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 CHILD'S HEALTH PLAN.

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

_____

Patient's Name

_____ _____

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 you 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 INFORMATION?

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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Social Skills Intake Questionnaire

Thank you for taking the time to fill out this form as completely and honestly as possible. Your input plays an important role in the evaluation process. All the information on this form is confidential and will not be released without your permission.

IDENTIFYING INFORMATION

Person Completing Form: _____ Relationship to Child:_____

Childs Name: _____ DOB: _____ □ M □ F

What are you hoping your child will get out of the social skills class?

What do you feel are your child's weaknesses related to social skills?

FAMILY BACKGROUND

Mother's Name: _____ Age: _____ Father's Name: _____ Age: _____

Occupation: _____ Occupation: _____

Is this child: □ Your Biological Child □ Step Child □ Adopted Child □ Foster Child
If not your biological child, at what age did he/she come into your home?

Persons Living in the home:

Language spoken in the home:

Does anyone related to this child have speech, language, learning or physical development problems? □ Yes □ No
If yes, please describe:

HEALTH / MEDICAL HISTORY **□NO KNOWN MEDICATION OR FOOD ALLERGIES**

Is the child currently in good health? □ Yes □ No
Is the child taking any medications? □ Yes □ No
If yes, please list medication(s), dosage, and why used:

Please list any food or medication allergies:

Has the child seen the following specialist? (Check all that apply)

□ Occupational Therapist □ Ear/Nose/Throat Specialist
□ Physical Therapist □ Neurologist □ Psychologist
□ Speech Therapist □ Ophthalmologist and/or vision Therapist □ Psychiatrist
□ Orthopedic Surgeon □ Other: _____

Please include names and phone numbers of specialist(s) and reasoning for seeing:

SOCIAL SKILLS QUESTIONNAIRE	
IF THE ANSWER TO ANY OF THE QUESTIONS IS 'NO' PLEASE PROVIDE SOME EXAMPLES	
Will our child remain with a group during outings? Example:	□ Yes □ No
Does your child follow the group routine? Example:	□ Yes □ No
Does your child follow verbal directions? Example:	□ Yes □ No
Does your child use appropriate attention seeking behaviors? Example:	□ Yes □ No
Does your child make transitions to the next activity when directed? Example:	□ Yes □ No
Does your child accept interruptions or unexpected changes? Example:	□ Yes □ No
Is your child able to answer simple social questions? (i.e.: name, age, address?) Example:	□ Yes □ No
Does your child initiate a conversation around specific topics? Example:	□ Yes □ No
Does your child maintain appropriate proximity to conversation partners? Example:	□ Yes □ No
Does your child maintain appropriate eye contact? Explain:	□ Yes □ No
Does your child pay attention to others nonverbal language and understand what is being communicated? Example:	□ Yes □ No
Does your child play with other children, such as sharing toys and talking about the play activities even though the play agenda of children may be different? Example:	□ Yes □ No

Does your child respond to interactions from peers? (i.e.: physically accepts toys from peers, answers questions) Example:	□ Yes □ No
Does your child play cooperatively with peers? (i.e.: roles during dramatic play, lead the play, games with rules) Example:	□ Yes □ No
Does your child take turns during unstructured activities? Example:	□ Yes □ No
Does your child have the ability to calm him/herself when upset? Example:	□ Yes □ No
Does your child have the ability to calm him/herself when their energy level is high? Example:	□ Yes □ No
Does your child use acceptable ways to express anger or frustration? Example:	□ Yes □ No
Does your child demonstrate aggressive behavior towards others? Example:	□ Yes □ No

_____ _____

Patient's Name (print) Patient's Signature (14+)

_____ _____

Parent/Guardian Name (Print) Parent/Guardian Signature

_____

Date:

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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).

Patient Signature (14+): _____ Date: _____

Parent/Guardian Signature : _____ Date: _____