THRIVE

HEAL THRIVE GROW BEHAVIORAL HEALTH

CLIENT INFORMATION SHEET
(Please be sure to fill out this form entirely, indicating N/A if not applicable)

Client Name_____ DOB_____S.S. #_____

*Age_____ Gender_____ Marital Status_____ Sexual Orientation_____

Home Address_____ City_____ State____ Zip_____

Home/Cell Phone_____ Work Phone_____ Can we leave a message?: ☐ yes ☐ no

Email Address_____ Preferred contact method: ☐ phone ☐ email

Job Title_____ Employer_____
Work Address_____
Work Phone _____ Can we leave a message? _____ yes ____ no

Students: Grade _____ School_____ School Counselor_____
Address_____Phone_____

Primary Physician_____ Date of last visit_____ ☐No Primary Physician
Address_____Phone_____
Emergency Medical Provider Name and Contact Number(s):_____
_____

Psychiatric Prescriber _____ Date of last visit_____ ☐ No Psychiatric Prescriber
Address _____ Phone_____

Who referred you to this office? _____
Address_____Phone_____
Reasons for referral? _____
_____
_____

Emergency Contact_____ Relationship_____

Address_____

Home/Cell Phone_____ Work Phone_____

***If minor under the age of 18 years old:**

Legal Guardian Name_____ DOB _____S.S. # _____

Relationship to client: Parent ____Other____ (check one) If other, specify relationship_____

Address_____

Phone (home) _____ (work) _____

Client or authorized person's signature: I authorize Health THRIVE Grow Behavioral Health to make contact with the referral source, my physician and my prescriber, for purposes of treatment planning and coordination of care.

_____ _____
Signature Date

_____
Printed Name

Updated 2.13.18

INFORMED CONSENT STATEMENT & OFFICE POLICY

The following statement answers important and frequently asked questions concerning the Heal Thrive Grow Behavioral Health (THRIVE). If you have further questions after reading this, or other concerns not covered here, please bring them, up with your therapist at your first appointment. Please keep one copy of this statement for your records. The original, signed and dated, will be kept in your file. It is very important that you read the entire statement carefully before signing.

Service Delivery Policies and Procedures

The first step in receiving services is to complete a mental health assessment with your therapists. You will then be provided information regarding service options. After your assessment you also have the right to be informed of your mental health diagnosis, as well as the right to discontinue treatment at any time. However, we encourage you to discuss the latter choice openly with your therapist first. Similarly, your therapist may need to terminate your treatment if, in his or her judgment, you are not benefiting from treatment or are non-compliant with treatment requirements. A full copy of all our service delivery policies and procedures will be made available to you upon request.

Possibilities, Risks, and Benefits

The goal of mental health treatment is to decrease targeted symptoms. There are some risks to treatment: Symptoms can worsen before they improve or may persist even after treatment is complete. New symptoms or treatment issues may emerge during the course of treatment. Progress related to mental health symptoms or issues can result in changes that have the potential to disrupt life patterns or interpersonal relationships. There are also many benefits to treatment: Individuals participating in mental health treatment often learn techniques to help cope with difficult emotions, change destructive patterns of thinking, improve functioning related to trauma or anxiety, improve interpersonal communication and demonstrate a positive impact overall behavior and personal wellness.

Complaints and Grievances

Any client who has a grievance arising from their treatment at Thrive Clinic may present their grievance, verbally or in writing, to their therapist or a clinic director. This individual will investigate the nature of the grievance and seek to reach an acceptable and reasonable resolution in a timely manner. All clients and their parents (or legal guardians where appropriate), will be offered a copy of our grievance policy at the time of their first appointment. All grievances will be kept confidential unless the law requires that they be disclosed, and if disclosure is so required, they will be disclosed to as few persons as possible. The receipt, investigation and action taken regarding the grievance shall be documented in the client's chart.

Additionally, clients are encouraged to take their grievance outside the program (e.g., to a licensing board, a state professional organization, a client rights advocacy group, the state insurance commissioner) if at any point they feel it is necessary to do so.

Confidentiality

We abide by the laws and ethical principles that govern privilege and confidentiality. We will not disclose to

anyone anything you tell us, not even the fact that you are a client in the program, without your written permission via a signed release of information form. There are a few exceptions to this standard:

1. It is legally required of us that we act to prevent physical harm to yourself or others when there is "clear and imminent" danger of that happening.
2. We are legally required to report cases of ongoing child, elder and disabled abuse.
3. We will tell the police and courts about any crime by a client committed at our program, or against any person who works for us, or about any threat to commit such a crime.
4. We may have to release clinical information regarding you to insurance carriers as required for payment or review of a claim.
5. We may have to release your records when ordered to do so by court subpoena. However, we will discuss the details of privilege with you beforehand and request a written release from you if we judge this to be in your best interest.
6. Occasionally, we may use a fax machine or email to send treatment plans, and other evaluations to your insurance company, specific agencies or other providers. Although we make every attempt to safeguard this information, faxed and emailed information is not necessarily guaranteed confidential.
7. Thrive Clinic staff may consult internal clinical supervisors about your treatment progress. If we need to consult outside our clinic, we would obtain your permission first and be careful to conceal your name or other identifying information.

Appointments and Cancellations

Individual sessions are arranged by appointment only. We will meet you at the exact time agreed upon. If we are late, we will make up the missed time or prorate your bill. If you are late, we will charge the full fee and you will lose that portion of time from your session. Cancellation of sessions should be avoided. If you need to cancel an individual therapy appointment, you will not be charged if you notify your therapist 24 hours in advance. If you no-show/no-call or late-cancel an appointment, you will be charged the full fee. Cancellations can be phoned into the office any time, day or night. Please be aware voicemail messages are date and time stamped.

Telephone Calls and Emergencies

Our voice mail service enables you to call our office at any time, day or night, and leave a message for a return call. We check our phone messages at least twice a day during weekdays and return calls as soon as possible. If you are unable to reach your Thrive Clinic therapist, call the Crisis Line at 503-988-4888 (Multnomah County), 503-291-9111 (Washington County), or 503-655-8401 (Clackamas County), or go to the nearest hospital emergency room.

Safety Policy

Thrive Clinic staff and client safety are of utmost importance. As such, any act of aggression to self, others or property while on site shall be reported as a critical incident to the director. A corrective action plan will be implemented to address the incident which may involve a written apology, compensation for damages, taking legal action, and/or immediate termination of Thrive services. Please note that minors must be accompanied by a responsible adult at all times while on Thrive Clinic premises and that it is his/her responsibility to monitor the

actions and whereabouts of the minor at all times.

Fees and Payment

There are charges for all program services, including therapy, consultations, preparation of special reports or treatment summaries, or other services you may request. We do not have a sliding fee scale, but do offer a few low fee slots for clients in financial hardship. Financial policy and procedures including program fees will be provided to you at the point of referral and/or intake. Once informed, you will be asked to sign a form indicating acknowledgement and agreement with Thrive Clinic's financial policies and procedures. We require that you inform us immediately of any change in your contact information.

Thrive Clinic reserves the right to change terms or parts of this consent at any time. We will post any changes in our waiting room with ample notice.

By signing below, I am indicating I have read, understand, and agree to the information presented in this informed consent.

_____ _____

Client Printed Name Date

_____

Client Signature

FINANCIAL POLICY

In the interest of a cooperative working relationship between Heal Thrive Grow Behavioral Health (THRIVE) and our clients, please carefully read the financial policy as described below. If you have any questions or concerns regarding this policy, we encourage you to speak with your therapist at your first appointment.

Billing and Client Fees: Client out-of-pocket expenses are due at the time of service. We do not bill insurance. However, we will be happy to provide you with a statement to submit to your health plan should you wish to recover your out-of-pocket expenses directly from them.

Client Delinquent Balances: Client balances are due in full within 30 days of receiving your monthly statement. During treatment, clients that have patient balances exceeding $500.00 must be paid in full in order to continue receiving services. You will be given adequate notice and referral options should your treatment at Thrive Clinic need to be postponed until delinquent patient balances have been resolved. Please be advised that accounts past due by 90 days, unless payment arrangements have been made with the billing department, may be sent to collections. As a courtesy to clients, a collections warning letter is sent indicating the status of your account. You will be given 10 working days to respond to this notice before action is taken. If you discontinue treatment at any time and your account is delinquent or assigned to collections, you will not be allowed to return to treatment until your balance has been paid in full. Further, if you name Thrive Clinic, or its clinicians, as a debtor when filing bankruptcy you will not be able to return for services.

Client Refunds*:* Client refunds are issued the 15th of every month once your account has been cleared. In other words, refunds will not be issued until your account has a zero balance and has been closed by your therapist.

Receipts: Receipts will be provided at the time of payment. We recommend that you maintain a record of your visits and payments for any reimbursement that your employer or health plan may require.

Returned Checks: There is a $25.00 processing fee on returned checks. We require that your returned check amount plus the processing fee be paid in full on or before your next scheduled appointment.

Appointments*:* Individual sessions are arranged by appointment only. We will meet the client at the exact time agreed upon. If we are late we will make up the missed time or prorate your bill. If the client is late we will charge the full fee and he/she will lose that portion of time from their session. Cancellation of sessions should be avoided. If the client needs to cancel an individual therapy appointment, he/she will not be charged for the appointment if he/she notifies their therapist 24 hours in advance of the scheduled appointment. If the client no-show/no-call or late-cancels an individual therapy or medication management appointment, they will be charged the full fee. Where 24 hours notice is given, the charge for a missed group session is $30.00. No show/no call or late cancelled group sessions are charged at the full rate. Fees charged for missed sessions are not reimbursable by insurance companies.

Fees*:* Assessment sessions range from $200.00 to $275.00 per hour. The fee for individual therapy services varies by clinician and ranges between $100.00 and $200.00 per hour. Psychological testing is paid at $185.00 per hour. Case management/coordination of care services are billed in 15-minute increments based on $100/hour fee. Medication management fees are as follows: Medication Evaluation; $275.00, Medication Management, $175.00 per 30 min session. For individuals in a financial hardship situation, we have a few low fee slots available.

Signing below indicates 1) I have read Thrive Clinic's financial policy, 2) I understand Thrive Clinic's financial policy, and 3) I agree to Thrive Clinic's financial policy.

Financially Responsible Party:

Name: _____ Relation to Client: _____

Signature: _____ Date: _____

Updated 2.13.18

INSURANCE WAIVER FORM

Date: _____

Services Provided: _____

Treatment Start Date: _____ Estimated End Date: _____

I, _____, acknowledge that although health care services as described above may be services covered by my health insurance policy or plan, I am voluntarily electing not to use my benefit to pay for these services. Instead, I choose to pay out-of-pocket, in full, for the services as described above.

I hereby release _____ Health Plans, Inc. and/or any other health insurance entity in which I am a participant from any and all payment responsibility relating to the services as described above.

-OR-

I plan on seeking reimbursement from my insurance plan using my out-of-network benefits and understand that the Thrive Clinic will not bill my insurance plan, however I may request a statement of services to submit to my health plan for reimbursement

By signing below, the client understands that he/she is voluntarily choosing not to use insurance to pay for the services as described above and as such, will be required to pay for these services out-of-pocket and in full.

_____ _____

Client Signature or that of Authorized Representative Date

_____

Client Name or that of Authorized Representative

THRIVE

HEAL THRIVE GROW BEHAVIORAL HEALTH

AUTHORIZATION TO CHARGE DEBIT/CREDIT CARD

Cardholder Name: _____

Date of Birth: _____ Phone: _____

Street Address: _____

City: _____State: _____ Zip: _____

CREDIT CARD #: _____

EXP. DATE: _____

Please attach a copy of the front and back of the card.

I, _____, authorize Heal THRIVE Grow Behavioral Health to charge the credit card as named above for health services rendered to _____ (client name).

Services that may be charged to this credit card include, but are not limited to the following:

- Mental Health Assessment
- Individual Therapy
- Family Therapy
- Group Therapy
- Med Management
- Nutrition Management
- Case Management Services
- Consultation
- Missed Session

Charges will be made at the time of service or monthly for balance due. This agreement will expire after treatment is terminated and no further charges are incurred.

_____ _____

Cardholder Signature Date

_____

Cardholder Printed Name

Updated 2.13.18

PATIENT EMAIL AND TEXT MESSAGE CONSENT FORM

Patient name:

_____

Email:

_____

Text message number(s):

_____

_____

1. RISK OF USING EMAIL AND/OR TEXT MESSAGE

Transmitting patient information by email or text has a number of risks that patients should consider before using email or text. These include, but are not limited to, the following risks:

a) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. Emails and text messages sent from Heal Thrive Grow Behavioral Health (THRIVE) are not encrypted, so they may not be secure. Therefore, it is possible that the confidentiality of such communications may be breached by a third party.
b) Email/texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) Senders can easily misaddress an email/text.
d) Email /text is easier to falsify than handwritten or signed documents.
e) Backup copies of email/text may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect email or text transmitted through their systems.
g) Email/text can be intercepted, altered, forwarded, or used without authorization or detection.
h) Email/text can be used to introduce viruses into computer systems.
i) Email/text can be used as evidence in court.

2. CONDITIONS FOR THE USE OF EMAIL/TEXT

THRIVE cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. Patients must acknowledge and consent to the following conditions:

a) Email is not appropriate for urgent or emergency situations. THRIVE cannot guarantee that any particular email will be read and responded to within any particular period of time.
b) Text messages may be used (at the therapists discretion) to initiate coaching calls with the therapist. However, the content of urgent phone coaching typically occurs over direct voice-to-voice communications.
c) All clinically relevant email/text will typically be printed and filed in the patient's medical record.
d) Practice will not forward patient identifiable emails/texts outside of the Practice without the patient's prior written consent, except as authorized or required by law.
e) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by email/text with Practice.

3. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email/text between THRIVE and me, and consent to the conditions and instructions outlined, as well as any other instructions that the THRIVE may impose to communicate with patient by email/text. If I have any questions, I may inquire with the Practice Privacy Officer.

Patient signature_____

Date _____

Would you like to receive appointment reminders via email? ☐ Yes ☐ No

Updated 3.7.18

THRIVE
HEAL THRIVE GROW BEHAVIORAL HEALTH

5200 SW Macadam Ave., Suite 580
Portland, OR 97239
Voice: (503) 290-3261 Fax: (503) 231-8153

Therapist: _____

___ Thrive is **SENDING** Records
___ Keep Release on **FILE** for Future Use
___ Thrive is **REQUESTING** Records

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

A. By signing this form, I, (client's full name) _____authorize the use and disclosure of my individually identifiable health information to/from:

_____

Person and Agency Represented (if applicable)

_____

Address and Phone/Fax Number

B. Purpose of Disclosure: Mental Health Treatment Planning and Continuity of Care. Health information that may be used or disclosed through this authorization is as follows:

____Assessment/Treatment/Coordination of Care ____Eligibility Determination ____Legal/Court/Corrections/Probation
____At the request of the client ____Other: _____

C. Specific Information to be Disclosed: By **initialing** next to a category listed below, I specifically authorize use of confidential information.

____ Psychiatric and Mental Health information as included in the records.
____ Alcohol and Drug Treatment information (Specifically protected under law)
____ AIDS/HIV/ other STD testing information (Specifically protected under law)
____ All health information about me as described above, *excluding* the following: _____
____ Specific health information including only: _____
____ Mail records certified if indicated by Thrive Clinic

D. I give permission to release my records from the following dates:

_____ _____
(approximate start date of treatment from provider above) (approximate end date of treatment from provider above)

E. I understand that my records are protected under the federal and state confidentiality regulation, including HIPAA, CFR 42 Part 2, RCW 71.05, 70.02, 71.34,74.04, 13.50.100(4)(b) and WAC 388-865-0436 or its successor, and can not be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time, but that in any event this consent expires automatically in **180 days** or shall remain in effect for the period of time reasonably needed to complete the request. I understand that I may refuse to sign this authorization and that such refusal will not affect my ability to obtain treatment from Thrive.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this authorization.

Date _____ Signature of Client _____

Print Client's Full Name _____

Client's Birth Date _____ SS#: _____

Date _____ Signature of Parent/Legal Representative* _____

*When client is not of legal age or competent to give consent, the signature of Parent or Legal Representative: _____

F. Redisclosure: If you give us permission to share your information with others, they may share your information without your consent. We cannot ensure that your information will be protected by others. However, some instances of State and/or Federal law may protect your information from being shared with others if it is information about HIV/AIDS, mental health, genetics, or drugs/alcohol.

G. Information about treatment, payment, and insurance: If your written permission to release health information about you is needed to determine your eligibility for medical programs and you do not give us permission to release your health information, then you may not be able to show that you are eligible. If another health care provider has asked us to provide a health care service to you, such as a test or evaluation, and you do not give us written permission to release your information to them, then we may not provide you with that health care service.

To the recipients of protected health care information: The information that has been disclosed to you from this authorization is protected by State laws (ORS 179.505, 192.525) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not re-disclose this information with the written authorization from the person to whom the information pertains, or otherwise in accordance with the law.

THRIVE

HEAL THRIVE GROW BEHAVIORAL HEALTH

CLIENT SELF-REPORT FORM

Name: _____ **Date:** _____

Please check items that you consider problematic:

☐	Distractibility	☐	Panic attacks	☐	Impulsivity	☐	Reoccurring nightmares
☐	Sadness/depression	☐	Fear of being away from home	☐	Compulsive behavior	☐	Intrusive thoughts/images
☐	Hopelessness	☐	Anxiety/worry	☐	Hyperactivity	☐	Sleep difficulties
☐	Sleep problems	☐	Obsessive thoughts	☐	Irritability/anger	☐	Hypervigilance
☐	Change in appetite	☐	Social discomfort	☐	Aggression	☐	Flashbacks
☐	Loss of pleasure	☐	Suspicion/paranoia	☐	Frequent arguments	☐	Avoidance of certain people, places, situations
☐	Crying spells	☐	Visual hallucinations	☐	Sexual Problems	☐	Increased startle response
☐	Seasonal mood changes	☐	Racing thoughts	☐	Computer addiction	☐	Feeling detached/unreal
☐	Thoughts of death	☐	Hearing voices	☐	Relationship problems	☐	Losing time/dissociation
☐	Low self worth	☐	Poor memory/concentration	☐	Problems with pornography	☐	Wide mood swings
☐	Fatigue	☐	Homicidal thoughts	☐	Gambling problems	☐	Excessive energy
☐	Withdrawal from people	☐	Self-harm	☐	Work/school problems	☐	Alcohol/drug abuse
☐	Guilt/shame	☐	Loneliness	☐	Eating problems	☐	Other:
☐	Lack of motivation	☐	Boredom	☐	Parenting problems		

Additional symptoms or problems:

Previous or current diagnoses:

Please check areas that are affected by the above items:

☐Hygiene	☐Finances/ housing	☐Sexual activity	☐Recreational activities
☐Relationships	☐Work/school	☐Health	☐Handling daily tasks

History of problem:

Time period	**Details of problem**
Childhood	
Adolescence	
Young adulthood	
Adulthood	

Current treatment: ☐**No current treatment**

Provider	Name	Contact information	Summary of treatment (e.g. length of time, progress thus far)
Therapist			
Prescriber			
Treatment programs			
Community resources			

Previous treatment: ☐**No previous treatment**

Provider/program	Dates seen	Outcome

Psychiatric hospitalizations: ☐**No psychiatric hospitalizations**

Hospital	Dates	Reason

High risk behavior:

Suicidal behavior: ☐No suicidal behavior

☐	Frequent and severe
☐	Mild/moderate and occasional
☐	Frequent morbid, but not suicidal thoughts/images
☐	Current plan for suicide including timeline. Details:
☐	Gun in home or easy access

Suicide attempt (date/age)	Circumstances?	Treatment received

Self-harm behavior ☐No self-harm behavior

Type of self harm behavior	☐Cutting ☐Burning ☐Head banging ☐ Hitting self ☐Scratching ☐Other:
Circumstances?	

Aggressive behavior ☐No aggressive behavior

Type of aggressive behavior	☐Physical aggression toward others ☐Verbal aggression toward others ☐Destruction of property ☐ Cruelty toward animals ☐Other:
Circumstances?	

Trauma: ☐ **No trauma**

Type of trauma	☐Sexual abuse ☐Physical abuse ☐Emotional abuse ☐ Neglect ☐Other:
Circumstances?	

Legal history: ☐**No legal history**

☐On probation	☐ Convicted of felony	☐Involved in custody case	☐Legal charges
☐Convicted of misdemeanor	☐ Involved in divorce	☐ DUII	☐ Other:
Circumstances?			

Substance use/abuse: ☐**No substance use/abuse**

Current substance use/abuse	☐Alcohol ☐Marijuana ☐Cocaine ☐Methamphetamines ☐Ecstasy ☐Heroin ☐Inhalants ☐LSD ☐Steroids ☐Prescription medications, Type:
Quantity of substance use/abuse	Amount and frequency:
History of substance use/abuse	When started and how long:
Previous treatment	☐Outpatient ☐Residential ☐Day Treatment ☐Other:
Family history	☐Father ☐Mother ☐Siblings ☐Grandparents ☐Aunts/Uncles ☐Other:

Do you have withdrawal symptoms when not using substance (e.g. physical cravings, illness, anxiety)?
☐No ☐Yes, details:

Have you built tolerance for the substance (i.e. do you need to use more to get the same effect)?
☐No ☐Yes, details:

Do you have problems due to substance use (e.g. work, relationships, health, legal)?
☐No ☐Yes, details:

Medical History:

Height:	Weight:
Childhood illnesses:	☐Measles ☐ Mumps ☐Rubella ☐Chickenpox ☐Polio
Immunizations and date of last vaccinations:	☐Tetanus ☐ Influenza ☐Pneumonia ☐Hepatitis ☐Chickenpox ☐MMR (Measles, mumps, rubella)
General medical concerns (e.g. cancer, arthritis, heart, thyroid, neurological disease)	☐No ☐Yes, details:
Prenatal complications	☐No ☐Yes, details:
History of head trauma	☐No ☐Yes, details:
History of major accidents/illnesses	☐No ☐Yes, details:
Allergies (i.e. to food or medications)	☐No ☐Yes, details:
General medical illnesses that run in your family	
Other notes about your health	
Primary care provider	Name: Last visit:

Please list all prescription medications you are taking: ☐**No prescription medications**

Medication	Dosage	Duration	Prescribed by

Please list all prescription medications you have PREVIOUSLY taken: ☐**No prescription medications**

Name	Reason for Stopping

Please list all surgeries you have had: ☐**No surgeries**

Year	Reason	Hospital

Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola/Energy Drinks # of drinks per day?	
Alcohol	Do you drink alcohol? How many drinks per week? Are you concerned about the amount you drink? Have you considered stopping? Have you ever experienced blackouts when drinking?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Tobacco	Do you use tobacco? ☐ cigarettes. __ Packs/day ☐ Chew __ times/day ☐ Pipe ___times/day ☐ Cigars___#/day ____ Number of years of tobacco use _____ Year quit	
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No What recreational or street drugs do you use? How long have you used this drug? When was the last time you used any drug? Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No	

Is there anything else you want your therapist to know about you?

What are your goals for treatment?