EnergyMatters

INFORMED CONSENT

The following contains information about my practice and answers some important and frequently asked questions. If you have additional questions that are not covered here, please feel free to ask me.

At the initial session, we will discuss the specific problems for which you seek help. I need this information to formulate an assessment and treatment plan. We may also discuss questions you have regarding my policies and procedures. We will discuss the best treatment modalities for your specific needs and goals.

As a psychiatric nurse practitioner, my services include assessment, diagnosis, psychoeducation, and supportive therapy. I am certified to treat individuals across the lifespan and primarily specialize in older adolescents and adults. Together we will explore elements of a healthy lifestyle that play a significant role in wellness. This may include collaboration or referrals to therapy or other providers; discussions about sleep, recreation, nutrition, and coping skills; and exploration of community connections and support that may also help you reach your goal. My therapeutic training is in Supportive and Interpersonal Psychotherapy, Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Collaborative Problem Solving, and Solution-Focused Brief Therapy.

CONFIDENTIALITY

Communication between patient and therapist is confidential, even if the patient is a minor, and may be shared only for the purpose of consultation without the patient or patient/ guardian expressing written consent. Information shared during therapy is kept confidential. I abide by the laws and ethical principles that govern confidentiality. I will not disclose to anyone anything you tell without you or your guardian's written permission. Below are a few exceptions to these standards:

- Clients under 18 years of age and their parents should be aware that, with some exceptions, the law may allow parents to examine their child's treatment record. Privacy in psychotherapy is often crucial to success. It is my policy to require an agreement from the parents that they will not access their child's records. In these cases, I will give parents an account of the overall goals of the child's treatment, my estimation of the degree of progress being made, and notification of any concerns I have regarding imminent and serious danger. Any other information will be provided at my discretion. Whenever possible, I will discuss such a release with the child in advance.
- The courts and state law stipulate that information cannot be kept confidential if a client is facing risk of harm. For instance, information cannot be kept private if someone discloses child abuse, abuse of an older adult, or plans to kill another person or themselves. If I suspect abuse, I may be required to report it.
- If someone commits a crime against the therapist, the police may be called.
- Non-custodial parents generally have the right to learn about treatment their child(ren) is receiving. Finally, if I am called to court, the court can order that information shared in counseling be disclosed.
- Clinical information may be released to insurance carriers as required for payment or review of a claim.
- Release of your records is necessary when ordered by court subpoena. However, I will discuss this with you beforehand and request a written release should this be in your best interest.
- There are times when I may seek peer consultation about your case. In that event, I will keep all of your identifying information confidential.

FEES, APPOINTMENTS AND CANCELLATION POLICY

Active client participation includes an acceptance of responsibility, a commitment to explore change, and a positive working alliance between the client and the therapist. Regular and on-time attendance to appointments is part of the responsibility. Appointments are reserved for you. If you are unable to attend a scheduled appointment, a 24-hour notice is recommended to avoid being charged. Appointments not canceled 24 hours in advance will be charged to you at the no-show fee. Please be aware that insurance companies do not reimburse for missed sessions. Therefore, the responsibility for payment rests with you. Under special or extenuating circumstances payment will be waived for the late cancellation or missed appointments. Messages or cancellations can be left on my voicemail. In the event that I will need to cancel your appointment, every effort will be made to advise you of the situation.

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You are expected to pay your fee or insurance co-pay at the time of each visit. If you have an annual medical insurance deductible, this will need to be paid before your insurance will begin this reimbursement. If benefits are exhausted or coverage is denied, you are expected to pay any unpaid balances before the continuation of treatment.

Below are estimated rates if you are not using insurance and for out of network billing:

- New Patient Intake, Evaluation & Assessment (60-90 min) Simple/ Complex $400-450
- Established Patient Evaluation & Management w/ Psychotherapy (40 min) $300
- Established Patient Evaluation & Management w/ Psychotherapy (25 min) $250
- Established Patient Evaluation & Management (15 min) $200 Established Patient Psychotherapy Only (50-60 min) $200-$250
- Sliding Fee Scale Available Upon Request

Fees will be charged in 15-minute increments for phone calls, written reports, reviewing chart notes, and case consultations with other professionals, teachers, family members, etc. per our hourly rate.

In the event your therapist is subpoenaed, the court orders a release of records, or your therapist is requested to testify, he/she is required to respond. Your therapist will discuss with you available options if any. Any time spent reviewing, compiling, and distributing records, talking with attorneys, parents and other professionals involved in the case, written testimony, transportation to court, court attendance, in-person testimony, or any action your therapist needs to take in this situation will be charged at our full hourly rate in 15 minute increments.

TELEPHONE CALLS AND EMERGENCIES

You may leave a voicemail at (971) 410-0660 for me at any time, day or night. In the event of a medical emergency you need to call 911 and or the mental health crisis line is (503) 215-7082. Other emergency resources include: Oregon Poison Center 1-800-222-1222, Portland Women's Crisis Line (domestic violence) (503) 235-5533, Sexual Assault Resource Center (503) 626-9111 or you can go to your local emergency room.

MISCELLANEOUS

If you chose to terminate therapy, you may sign a release of information to have your psychotherapy notes copied for another therapist. **Fees for copied records:** $30 for 1-10 pages, .50 per page for 11-50, .25 per page for 51+, $6.50 for electronic records postage. **Workers' Compensation Records:** .10 for one page, .50 for each additional page, $6.50 for electronic records postage.

I reserve the right to terminate your therapy with me. If in my opinion, I determine that you would be better served by working with another therapist, you need a higher level of care, there is non-compliance with treatment, threatening behavior, or for any other reason, I will inform you that our therapeutic relationship has terminated. I will provide you with appropriate referrals.

INFORMED CONSENT FOR TREATMENT

- I have had the opportunity to review the above information and agree to enter treatment under these conditions.
- I give my consent to receive treatment for myself and/or grant permission for treatment to be provided for my dependent family member(s).
- I give permission for my therapist to use consultants to plan services for myself and/or my family.
- I give permission for my therapist to release information as needed to secure any applicable insurance benefits.

Client Signature: _____ Date _____

Parent/Legal Guardian: _____ Date _____

Parent/Legal Guardian: _____ Date _____

Julia Epstein, PMHNP: _____ Date _____

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INTAKE EVALUATION

IDENTIFYING INFORMATION:

Name: _____ Date: _____

Address: _____ City, State & Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ May we leave a message? yes ○ no ○

Gender assigned at birth: _____ Pronouns: _____ Age: _____ Date of Birth: _____

Place of birth: _____

Employer: _____ Occupation: _____

Social Security Number: _____

EMERGENCY CONTACT: Name: _____ Cell Phone: _____

Work Phone: _____ Relationship: _____

Others living in the home: (Please include Name, Date of Birth & Relationship to Client)

_____

Other family involved in care outside the home: (Please include Name, Date of Birth & Relationship to Client)

_____

Marital Status: _____ Spouse/Partner's name (if applicable): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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INSURANCE INFORMATION:

Name of Policy holder: _____ Date of birth: ___/___/___

Address of Policy holder: _____ City, State & Zip: _____

Relationship to client: _____

Insurance Company: _____ Telephone: _____

Insurance Company Address: _____ City, State & Zip: _____

Employer of Policy Holder: _____

ID # of Insured: _____ Group #: _____

INSURANCE INFORMATION (Secondary):

Name of Policy holder: _____ Date of birth: ___/___/___

Address of Policy holder: _____ City, State & Zip: _____

Relationship to client: _____

Insurance Company: _____ Telephone: _____

Insurance Company Address: _____ City, State & Zip: _____

Employer of Policy Holder: _____

ID # of Insured: _____ Group #: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to the party who accepts assigned or to myself. I authorize payment of medical benefits to the provider of services.

Client Signature: _____ Date: _____

Client's Name: _____

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PATIENT HISTORY

REFERRING PROVIDER/COUNSELOR: _____

PRIMARY CARE PROVIDER: _____

What pharmacy do you use for prescriptions? _____

Location: _____ **Phone Number:** _____

Rx Bin #_____ **PCN#**_____ **Group#**_____

Please list all medications, including dosage and frequency:

_____

_____

_____

_____

Please list al allergies, including medication, food and environmental:

_____

_____

_____

FAMILY HISTORY

Psychiatric History

Father: _____ Children: _____

_____ _____

Mother: _____ Siblings: _____

_____ _____

Extended Family Psychiatric Problems Past and Present:

Maternal Relatives: _____

Paternal Relatives: _____

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Medical History	You	Family	Which Family Member?
Thyroid Disease	☐	☐	_____
Anemia	☐	☐	_____
Liver Problems	☐	☐	_____
Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____
Asthma	☐	☐	_____
Stomach or Intestinal Pain	☐	☐	_____
Cancer	☐	☐	_____
Chronic Pain	☐	☐	_____
Heart Disease	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____
High Blood Pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
Head Injury	☐	☐	_____
Bipolar Disorder	☐	☐	_____
Depression	☐	☐	_____
Suicide	☐	☐	_____
Schizophrenia	☐	☐	_____
Post Traumatic Stress Disorder	☐	☐	_____
Other Substance Abuse	☐	☐	_____
Other	☐	☐	_____

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Current Symptoms Checklist

Fatigue or loss of energy	☐	Sleep pattern disturbance	☐
Decreased interest in activities or excessive guilt	☐	Low self-esteem	☐
Depressed or sad mood	☐	Suspiciousness	☐
Weight or appetite change	☐	Low motivation	☐
Poor concentration	☐	Excessive energy	☐
Worthlessness	☐	Excessive worry	☐
Decreased libido	☐	Irritability	☐
Hallucinations	☐	Panic attacks	☐

Other: _____

Current Medical Problems:

_____

_____

_____

_____

Menstruating Patients: Date of last menstrual period _____

Are you currently pregnant or think you might be? Yes ☐ No ☐

Are you planning to get pregnant in the near future? Yes ☐ No ☐

Birth control method: _____

# of pregnancies _____ # of live births _____ # of living children _____

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MEDICAL INFORMATION

Current Psychiatric Provider: _____

Therapist/Counselor_____

PSYCHIATRIC HOSPITALIZATIONS **Yes** ☐ **No** ☐

Where: _____

Dates: _____

Reason: _____

HAVE YOU BEEN PRESCRIBED PSYCHIATRIC MEDICATIONS? **Yes** ☐ **No** ☐

Who prescribed your medications? _____

SUBSTANCE USE HISTORY:

Caffeine:	**Yes** ☐	**No** ☐	**Cups/Ounces/ Day** _____
Energy Drinks:	**Yes** ☐	**No** ☐	**Ounces/ Day** _____
Tobacco:	**Yes** ☐	**No** ☐	**Packs/Day** _____
Alcohol:	**Yes** ☐	**No** ☐	**Drinks/ Day** _____
Recreational Drug Use:	**Yes** ☐	**No** ☐	**Type & Amount:** _____

PRIOR TREATMENT FOR SUBSTANCE USE OR CHEMICAL DEPENDENCY

Where: _____ Dates: _____

Reason: _____

What are the top 3 things you would like help with?

1. _____

_____

_____

2. _____

_____

_____

3_____

_____

_____

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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 I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am 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.I am required to abide by the terms of this Notice of Privacy Practices. I 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 I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I 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. I may disclose PHI to any other consultant only with your authorization.

For Payment. I 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. I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I 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, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes pm will be disclosed only with your authorization. I may use your PHI to remind you of appointments.

Required by Law. Under the law, I must make disclosures of your PID to you upon your request. In addition, I 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.

- Abuse and Neglect reporting and investigation
- Judicial and Administrative Proceedings
- Deceased Persons
- Emergencies (including immediate risk to self or others)
- Family Involvement in Care
- Health Oversight
- National Security

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (sue as the social work licensing board or the health department)
- Required by Court Order
- 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.

Verbal Permission. I may 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.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to your therapist at: 3325 NE Wasco St, Portland OR 97232

- **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 may be 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. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I 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. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing at 3325 NE Wasco St, Portland OR 97232, 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. **I will not retaliate against you for filing a complaint.**

The effective date of this Notice is August 20, 2018.

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Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Patient/Client Name: _____

Date of Birth: _____

Social Security #: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact my therapist at: 3325 NE Wasco St, Portland OR 97232

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, heath care surrogate, etc):

☐ Patient/Client Refuses to Acknowledge Receipt:

_____ _____

Signature of Staff Member Date