A HEALING INTENTION, LLC
BEHAVIORAL HEALTH WELLNESS CENTER

A Healing Intention, LLC
12655 SW Center Street
Suite 320
Beaverton OR 97005-1600
503-303-0304

1. AHILLC Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a mental health professional licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with HIPAA and the NASW Code of Ethics.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this disclosure as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization at our discretion: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Contact@ahealingintention.com

Right of Access to Inspect and Copy.

You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend.

If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

Right to an Accounting of Disclosures.

You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions.

You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication.

You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

Breach Noticification

If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice.

You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Contact@ahealingintention.com or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

ACKNOWLEDGEMENT

I acknowledge that I have reviewed and accepted provisions on this page(s) verified by my signature on last page of Intake packet: Please Initial:

EFECTIVE DATE OF THIS NOTICE IS NOVEMBER 2020

A Healing Intention, LLC, Main Office: 12655 SW Center Street, Suite 320, Beaverton OR 97005 * TEL: 503-303-0304 * FAX: 503-465-5901

2. AHILLC Client Rights and Responsibilities

RIGHTS AND RESPONSIBILITIES

This is a list of your rights and responsibilities when getting services from A Healing Intention, LLC. Please read it carefully. Please use your rights and responsibilities. YOUR RIGHTS:

1. You have the right to be treated with dignity and respect.

2. You have the right to pick the therapist who works with you and the place you go to see them.

3. You have the right to be told of: Treatment options; Consequences of treatment; Your diagnosis; Covered and non-covered services; Your right to refuse services.

4. You have the right to receive services without discrimination because of race, color, religion, sex (including gender identity), national origin, political affiliation, sexual orientation, marital status, disability, genetic information, or age.

5. You have the right to receive the services you need.

6. You have the right to be protected. If you or anyone you work with thinks you are being abused, you have the right to an investigation and a safe place to stay during the investigation, even if the person hurting you is a member of your family. The State of Oregon defines abuse as: Any injury that is not accidental, or that you can't explain; When someone hurts you on purpose;When someone makes sexual comments or acts sexual with you and you do not like it.

7. Clients have the right to be told how much therapy will cost per hour and the right to accept or reject the fee which is due at each session. You also have the right to be informed of the policies for charges, billing third parties, and making and breaking appointments.

8. You have the right to have a friend, family member, or advocate with you at your appointments if appropriate for your care.

9. You have the right to receive care that serves your needs and is given by staff that has the appropriate training and skills.

10. You have the right to involve your family, if you choose, with questions and concerns you may have about your health care.

11. You have the right to be involved in your care plan, including: Inviting a friend, family member, or advocate to help you; Understanding your medications and their side-effects; Receiving a referral for special services you are eligible for.

12. You have the right to file a complaint if you are dissatisfied with the services you receive here and you will not be treated differently without an explanation. You have the right to understand your ability to make a complaint and where you can do so directly from your independently contracted clinician working with A Healing Intention LLC.

13. Confidentiality. AHI will not disclose your confidential information unless directed by you except in the following conditions;

14. Your file is kept a minimum of at least 7 years from first date seen. For minors, this seven-year period begins when you turn 18 years old. The agency file contains a copy of this informed consent, with your client information form, and all materials that pertain to you, including session notes. This file is confidential with the exceptions noted above. Your file is protected by locked cabinet and will be destroyed by shredding at the end of seven years.

15. You have the right to say in writing, ahead of time, how you would want to be treated if you were seriously ill or injured

and you were unable to make decisions or express your wishes. We will help you with this form if you ask us to and if you are your own guardian.

16. You have the right to receive, and have explained to you, written information about: Rights and Responsibilities; Benefits available; Fees charged to you, if any; How to access services; What to do in an emergency; How to make a complaint or file a grievance.

YOUR RESPONSIBILITIES:

Client Agrees to:

To agree to therapy and participate in therapy; To work on goals or assignments; To keep your appointments and call 24 hours in advance if you are unable to keep your appointment; To keep information about others confidential as you would wish it to be for yourself; To supervise your children in the waiting room or other areas of the building; To pay for your therapy services on time; To take care of yourself, acquire adequate sleep, nourishment, and care; To discuss any grievances you may have with your therapist; To understand your rights under the Health Insurance Portability and Accountability Act (HIPAA) In group settings, to keep information about others confidential as you would wish it to be for yourself If you need support immediately and cannot wait for us to return your message, please call the Multnomah County Crisis Line at 503-988-4888 or the Washington County Crisis Line at 503-291-9111. , please call 911 or go to the nearest emergency room or hospital.If you believe you may be a risk to the safety of yourself or others you should immediately call 911

For complaints regarding services received at AHI, please contact:

Oregon Health Authority; Addictions and Mental Health Services (AMH), 500 Summer Street NE Salem, OR 97301-1079 Phone: 503-945-5772 Email: amh.web@state.or.us

OR

U.S. Department of Health & Human Services - 200 Independence Avenue, S.W. - Washington, D.C. 20201

ACKNOWLEDGMENT

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3. OHP/CO Welcome

OHP/Health Share/CareOregon Clients

We are glad to have you as our client here at A Healing Intention, LLC. We are governed in providing services through the Oregon Health Authority, Health Share of Oregon, and Multnomah, Washington and Clackamas counties. The funding for Medicaid is limited in nature and therefore our services are required to be time-limited.

Your therapist will discuss the options for services available. Our therapy consists of an initial service of four weekly sessions, followed by bi-weekly sessions to meet your needs. If this is not adequate, a referral to a higher level of care will be necessary to ensure your behavioral health care needs are met.

I acknowledge that I have reviewed and accepted my submission on this page(s) verified by my signature on last page of Intake packet: Please Initial:

4. AHILLC Client Registration

Office Use Only:

☐ **Beaverton Main Office**

☐ **Clackamas Satellite Office**

CLIENT INFORMATION

Last Name::

First Name::

Middle Initial::

Date of Birth::

Age::

Gender::

Race:

Ethnicity:

Indian Tribal Affiliation?:

Education level? i.e high school, college, GED?:

Are you a Veteran?:

Last 4 Digits of SSN::

Marital Status::

Employer and Address::

Home Address::

City.:

State::

Zip Code::

Responsible Party/Parent (person responsible for signing this form)

☐ Same As Above (No Need to Complete)

Last Name:

First Name:

Middle Initial:

Date of Birth:

Age:

Sex:

Last 4 Digits of SSN:

Marital Status:

Employer and Address:

Home Phone:

Work Phone:

Email:

Relationship to Client:

PRIMARY INSURANCE INFORMATION:

Insurance Company Name::

Claim Address::

Insurers Telephone #:

ID#:

Group Name and Number::

Insured Party::

Effective Date::

Deductible/Copay:

Relationship to Client::

OTHER INFORMATION

Referred By::

Primary Care Provider::

Emergency Contact::

Phone::

I hereby guarantee payment for the entire balance of the above named client. I authorize treatment of the above named

client. I assign and authorize payment of medical benefits directly to AHI and/or its representatives. I authorize release of any information, including confidential medical records, requested by insurance companies, payors or government agencies in connection with this assignment. To cancel an appointment, the above named client must notify AHI at least 24 hours prior to the scheduled appointment time., or else I will be responsible for a $25 dollar cancellation fee. If the above named client fails to attend an appointment, I will be responsible for paying a $50 missed appointment fee. I have read, understand, agree to the described disclosure, financial policy, and various releases and guarantee.

ACKNOWLEDGMENT

I acknowledge that I have reviewed and accepted provisions on this page(s) verified by my signature on last page of Intake packet: Please Initial:

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5. AHILLC New Client Intake

Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms

(check all that apply)

- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Crying Spells
- ☐ Depression
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Guilt
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Irritability
- ☐ Libido Changes
- ☐ Loss of Interest
- ☐ Panic Attacks

- [ ] Racing Thoughts
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental conditions:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuanna
- ☐ Hallucinogens (LSD)
- ☐ Heroin
- ☐ Methamphetamines
- ☐ Cocaine
- ☐ Stimulants (Pills)
- ☐ Ecstasy
- ☐ Methadone
- ☐ Tranquilizers
- ☐ Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want your therapist to know?:

ACKNOWLEDGMENT

I acknowledge that I have reviewed and accepted MY SUBMISSIONS on this page(s) verified by my signature on last page of Intake packet: Please Initial:

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A HEALING INTENTION, LLC
BEHAVIORAL HEALTH WELLNESS CENTER

DSM-5 Self-Rated Measurement —Adult

Name_____**DATE**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

7. Telehealth Consent to Treatment

Informed Consent for Telehealth Services

This form is designed to allow you to give informed consent for the use of video/audio technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

I understand that therapy conducted online is technical in nature and that problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, I agree to call my therapist. There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows: · You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate. · I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this intake packet indicates that you understand I will only contact this individual in the extreme circumstances stated above.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation. IN ORDER TO HELP PROTECT THE THERAPUETIC PROCESS ONLINE, I AGREE TO THE FOLLOWING: • • Therapy conducted through telehealth requires that a therapeutic environment is maintained. It is requested that you behave in a manner consistent with an in-person therapy session; in a private and secure location, not engaging in activities that will prevent you from focusing on your therapy. •• Headphones/earbuds are recommended so that conversations are more private and protected. •• If someone enters your room or personal space, alert your clinician, cover your screen, and reduce the volume to 0. You may need to exit the session until you are alone again. If you are unable to return to your session, email or call your clinician to explain your exit. •• Use a secure Wi-Fi/Internet connection instead of public or free Wi-Fi. •• Do not record or take screenshots of the sessions. •• If you are not able to ensure these required parameters, you may request an audio only session.

Please list your ECP here:

Name:

Telephone Number:

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

ACKNOWLEDGMENT

I acknowledge that I have reviewed and accepted provisions on this page(s) verified by my signature on last page of Intake packet. Please Initial*:

8. AHILLC Consent for Treatment

Consent for Treatment

Welcome to A Healing Intention, LLC (AHI). This document contains important information about the professional services and business policies of this agency. When you sign this document, it will represent an agreement between you and AHI. AHI is a group agency that employs independently contracted clinicians also referred to as behavioral health professionals in this document. Each independently contracted clinician will provide a Professional Disclosure Statement to you that will describe their services, attendance policy, approach to treatment and resources if you are not satisfied with services provided. Please feel free to discuss any questions you have when you sign this or at any time in the future with your behavioral health professional. Please note that your behavioral health professional may be an intern who is working on their professional license under supervision of a licensed behavioral health practitioner.

Behavioral Health Services

Therapy is a relationship between people that is successful in part because of clearly defined rights and responsibilities held by each person. As a client in behavioral health services, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. These rights and responsibilities are provided to you in the intake package.

Behavioral health therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. This may be because the process of therapy often requires discussing the unpleasant aspects of your life. However, therapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems.

Appointments

Appointments will normally be 45-60 minutes in duration, once per week at a mutually agreed upon time, with some sessions more or less frequent depending on insurance coverage. The time scheduled for your session is assigned to you only. If you need to cancel or reschedule a session, we ask that you provide us with 24hours notice. If an appointment is cancelled with less than24 hour notice and depending on your insurance coverage, our policy is to collect the amount of your session, unless this was due to circumstances beyond your control. We will always try to reschedule. You are responsible to arrive on time; if you are late, your session will still end on time. Our NO SHOW policy is that if you miss your scheduled appointment with no notice, two (2) times in a 30-day period, an attempt will be made to address the specific difficulties in keeping your scheduling commitments, including speaking with someone other than your assigned clinician. Your independently contracted clinician may have a different policy for no shows/cancellations which will supersede this policy. If there is no resolution, you will be provided a referral list to other providers and be discharged from the agency and a secure email will be sent through the A Healing Intention LLC client portal system.

Professional Fees

The standard fee for the initial intake is $130.00 and each subsequent session is $145.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by cash, check or credit card. Any checks returned to our office are subject to an additional fee of up to $25.00 to cover the bank fee that AHI incurs. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, AHI charges on a prorated hourly basis for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of us. If you anticipate becoming involved in a court case, we recommend that you discuss this fully before you waive your right to confidentiality. If your case requires your therapist's participation, you will be expected to pay for the professional time required even if another party compels us to testify.

Clinical Records

AHI is required to keep appropriate records of the psychological services that we provide. Any communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with TheraNest, a secure storage company who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. An AHI behavioral health professional will keep brief records noting that you attended a session, your reasons for seeking therapy, the goals and progress set for treatment, your diagnosis, topics discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, AHI recommends that you initially review them with your therapist, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

Confidentiality

AHI policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices which was provided to you in the intake packet. Your independently contracted behavioral health professional will discuss this important document during your first session. Please remember that you may reopen the conversation at any time during your time here.

Parent and Minors

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is AHI policy not to provide treatment to a child under age 13 unless s/he agrees that we can share whatever information the behavioral health professional considers necessary with a parent. For children 14 and older, AHI requests an agreement between the client and the parent(s) allowing us to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child’s agreement, unless AHI feels there is a safety concern, in which case we will make every effort to notify the child of our intention to disclose information ahead of time and make every effort to handle any objections that are raised.

Contacting Your Behavioral Health Professional

A Healing Intention LLC is not designated as a crisis center. Often your behavioral health professional may not be immediately available by telephone. Phones may not be answered when we are with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. In general, calls will not be returned during weekend and holiday hours. If you need support immediately and cannot wait for us to return your message, please call the Multnomah County Crisis Line at 503-988-4888 or the Washington County Crisis Line at 503-291-9111. If you believe you may be a risk to the safety of yourself or others, please call 911 or go to the nearest emergency room or hospital.

PLEASE PLACE INITIALS IN EACH BOX:

Consent to Behavioral Health Services: I hereby consent to receive services from A Healing Intention, LLC (AHI). I understand that I may discontinue services whenever I choose. Please Initial.:

Receipt of Patient Rights and Responsibilities: I acknowledge that I have been informed of my rights and responsibilities as a client and have received a copy of the A Healing Intention, LLC Patient Rights and Responsibilities. Please Initial.:

Receipt of Notice of Privacy Practices: I acknowledge that I have received a copy of A Healing Intention, LLC Notice of Privacy Practices. Please Initial.:

Assignment of Benefits and Release of Information: I hereby authorize the release of any medical, dental, mental health, alcohol and drug, or other relevant information necessary to secure payment for claims filed on my behalf by A Healing Intention, LLC from the first date of service until all services have been paid for after the end of my treatment. I authorize payment of medical benefits to A Healing Intention, LLC for services received. I acknowledge that any balance not covered by or paid by my insurance is my legal responsibility. I agree to notify A Healing Intention, LLC immediately of any changes in my insurance. Please Initial.:

Assignment of Benefits and Release of Information: I understand that I am expected to pay for the services received based on A Healing Intention, LLC standard fee schedule. All patients are required to pay copayments, deductibles, and non-covered services at the time of your visit. If you do not have insurance, you will be asked to pay for your services, in full, at the time of your visit. I understand that I can pay via cash, check, Visa, or MasterCard. Please Initial.:

ACKNOWLEDGMENT

I acknowledge that I have reviewed and accepted provisions on EACH page of this intake packet verified by my signature located below this line.

NAME_____ **DATE**_____

_____

SIGNATURE

A Healing Intention, LLC, Main Office: 12655 SW Center Street, Suite 320, Beaverton, OR 97005 * TEL: 503-303-0304 * FAX: 503-465-5901