Phone: 503.352.0240
Fax 971.279.5635
www.nhws.us

NEW HORIZONS
WELLNESS SERVICES, LLC

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

# PATIENT INFORMATION AND INSURANCE FORM

☐ New Patient ☐ Change of Address ☐ Updated Insurance Info ☐ Returning Patient (after 3 months)

## PATIENT INFORMATION

Patient Name: _____ D.O.B. _____ ☐ M ☐ F
First M.I Last

| Parent(s)/Responsible Party | Phone Number(s) Home | Work | Cell | Email |
|---|---|---|---|---|
| Mother Name: | | | | |
| Father Name: | | | | |
| Caregiver Contact Information: | | | | |

Name

Address: _____ _____
Street City, State Zip Code

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

## PHYSICIAN'S INFORMATION

Primary Physician: _____ Address: _____
Phone: _____

Referring Physician: _____ Address: _____
☐ *Same as above*
Phone: _____

## INSURED'S INFORMATION

Name: _____ D.O.B. _____ ☐ M ☐ F
Last First

Employer: _____ S.S.N. _____

Insurance Company: _____ I.D. #: _____

Group #: _____

Insurance Address: _____ _____ _____
Street City, State Zip

Insurance Phone Number: _____

### SECONDARY INSURANCE INFORMATION

Name: _____ D.O.B. _____ ☐ M ☐ F
Last First

Employer: _____ S.S.N. _____

Insurance Company: _____ Subscriber: _____

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 Signature Witness (to be signed by Staff Member)

ID Copied: ☐ Yes ☐ No

503.352.0240
Fax 971.279.5635
www.nhws.us

NEW HORIZONS
WELLNESS SERVICES, LLC

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

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: _____

Child's Name: _____ Date of Birth: _____ ☐ 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 KNOW MEDICATION OR FOOD ALLERGIES

Is the child currently in good health? ☐ Yes ☐ No

Is the child taking any medications? ☐ Yes ☐ No

**Please list any food or medication allergies:**

If yes, please list medication(s), dosage, and why used:

Has the child seen the following specialists? (check all that apply)

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

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

Explain reason child is seeing specialist(s):

## SOCIAL SKILLS QUESTIONNAIRE

**IF THE ANSWER TO ANY OF THE QUESTIONS IS 'NO' PLEASE PROVIDE SOME EXAMPLES**

Will your child remain with a group during outings? ☐ Yes ☐ No
Example:

Does your child follow the group routine? ☐ Yes ☐ No
Example:

Does your child follow verbal directions? ☐ Yes ☐ No
Example:

Does your child use appropriate attention seeking behaviors? ☐ Yes ☐ No
Example:

Does your child make transitions to the next activity when directed? ☐ Yes ☐ No
Example:

Does your child accept interruptions or unexpected changes? ☐ Yes ☐ No
Example:

Is your child able to answer simple social questions? ☐ Yes ☐ No
*(i.e.: name, age, address?)*
Example:

Is your child able to respond to simple "wh" questions? ☐ Yes ☐ No
*(i.e.: What color is that ball?)*
Example:

Does your child ask "wh" questions for information? ☐ Yes ☐ No
*(i.e.: Who is that boy/girl?)*
Example:

Does your child initiate a conversation around specified topics? ☐ Yes ☐ No
Example:

| **SOCIAL SKILLS QUESTIONNAIRE** *(CONTINUED)* | | |
|---|---|---|
| Does your child maintain appropriate proximity to conversation partners?<br>Example: | ☐ Yes | ☐ No |
| Does your child maintain appropriate eye contact?<br>Example: | ☐ Yes | ☐ No |
| Does your child pay attention to others nonverbal language and understand what is being communicated?<br>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?<br>Example: | ☐ Yes | ☐ No |
| Does your child respond to interactions from peers?<br>*(i.e.: physically accepts toys from peers, answers questions)*<br>Example: | ☐ Yes | ☐ No |
| Does your child play cooperatively with peers?<br>*(i.e.: roles during dramatic play, lead the play, games with rules)*<br>Example: | ☐ Yes | ☐ No |
| Does your child take turns during unstructured activities?<br>Example: | ☐ Yes | ☐ No |
| Does your child have the ability to calm him/herself when upset?<br>Example: | ☐ Yes | ☐ No |
| Does your child have the ability to calm him/herself when their energy level is high?<br>Example: | ☐ Yes | ☐ No |
| Does your child use acceptable ways to express anger or frustration?<br>Example: | ☐ Yes | ☐ No |
| Does your child demonstrate aggressive behavior towards others?<br>Example: | ☐ Yes | ☐ No |

503.352.0240
Fax 971.279.5635
www.nhws.us

NEW HORIZONS
WELLNESS SERVICES, LLC

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

# SERVICE AGREEMENT

Welcome to New Horizons Wellness Services, LLC! This document (the agreement) contains important information about our business policies and professional services. **Although this document is long, it is very important that you read these policies carefully and ask for clarification when needed.** When you sign this document, it represents a formal agreement between you and New Horizons Wellness Services, LLC.

## CLINIC OVERVIEW

We are a private, multidisciplinary clinic that focuses on helping children, adolescents, adults, and families with physical, developmental, speech and language, social, emotional, cognitive, and learning concerns. Our services include counseling for individuals, families, and couples; groups; therapeutic clubs; diagnostic evaluations; occupational & speech therapy; and consultation.

## APPOINTMENTS

Appointments are scheduled following the initial evaluation. Please check with the front desk after the initial evaluation to schedule on-going treatments. **(Note: You may not be scheduled with the same therapist that preformed the initial evaluation)**. The frequency of treatment will be determined by the therapist. We will do our best to accommodate your needs, but cannot guarantee your preferred day and/or time request. If you are provided with an ongoing time slot and miss your appointment without providing 24hr notice (see below) or have multiple rescheduled appointments, the time slot will be made available to other patients going forward. If we cannot meet your request, you, your child, and/or family will be placed on our waiting list and will be notified if it becomes available.

**Wait List Procedure:** We cannot guarantee a time frame or when your preferred time will become available. Time slots are offered first to current patients on the therapy schedule. If we are unable to fill the time slot, calls are then placed to patients on our wait list according to the date they were added on a first come, first serve basis.

## ATTENDANCE

It is important that all scheduled appointments be kept and attended on time. Late arrivals reduce the amount of direct service time. We understand that there may be times that attendance is not possible (e.g., illness, family emergency).

- **Illness:** If you, your child, or one of their siblings is sick or has a fever please do not bring them to the clinic. If your child has experienced vomiting or diarrhea, please make certain they have been symptom free for at least 24 hours before bringing them to the clinic. Exceptions to the cancellation policy are made in instances of illness or emergency.
- **Cancellations and Rescheduling:** To cancel a scheduled therapy or consultation appointment, please call during office hours and give <u>at least 24 business hours advance notice.</u> **The full fee is charged for appointments missed and appointments cancelled less than 24 hours in advance.** Cancellations left on voicemail after business hours will be considered received as of the next business day. It is important to note that insurance companies do not provide reimbursement for missed or cancelled sessions. If you must cancel an evaluation appointment, please notify us **<u>at least one week in advance</u>**. We may elect not to reschedule evaluations cancelled without sufficient notice.

- **Late Arrivals and Pick-up:** You must arrive timely for your therapy session or evaluation. If you arrive late for a scheduled appointment, the appointment will still end on time. Please be advised that you will be charged for the full amount of time that was allotted for the appointment.

  If your occupational therapy session is not able to start within **8 minutes** of its scheduled start time you will be required to pay privately for the first 15 minutes of the session. (See Financial Agreement)

  If you will not be attending your child's therapy session, you must be in the lobby 10 minutes prior to the scheduled end time. We do not provide childcare services. You may be charged if you fail to pick-up your child at the scheduled end time. (See Financial Agreement)

- **No Shows:** If you fail to keep a scheduled appointment and have not cancelled you will be charged the **full fee** for the session. If your child is scheduled for more than one discipline on a given day, the cancellation and or no show fee will apply to each scheduled appointment missed.

## CONFIDENTIALITY AND PATIENT'S RIGHTS

The law protects the privacy of all communications between a patient and health care provider. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Please note that we do discuss cases internally at New Horizons Wellness Services, LLC in peer supervision and case consultation with other health and mental health professional, and by signing you give permission for these discussions. During a consultation, we make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential.

As a general rule, outside of peer consultation, we will not disclose information regarding a patient unless authorized to do so by the patient in writing. There are several situations in which the Oregon State law requires clinicians to make exceptions to the confidentiality of communications between patient and clinician. These situations are:

- when there is suspected child, elder, or disabled abuse
- when there is threat of harm to self or others
- when medically relevant information is needed for emergency medical treatment
- when records are subpoenaed by order of a Judge, or if the client waives confidentiality
- when conducted at the request of an outside agency with the client's approval

## HIPAA NOTICE OF POLICIES AND PRACTICES

New Horizons Wellness Services, LLC is committed to preserving the privacy of your personal health information. Additionally, we are required by Federal law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State law to protect the privacy of your personal information and to give you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the HIPAA Notice of Policies and Practices should you wish to have a complete copy for your records.

## MINORS AND PARENTS

In the state of Oregon, minors 14 years of age and older are able to independently consent to or receive mental health services and to disclose/release information without parental permission. While privacy in psychotherapy is very important, particularly with adolescents, parental involvement is also essential to successful treatment and this may require that some private information be shared with parents. It is our policy not to provide mental health services to children under the age of 18 unless they agree that we can

share general information about the progress of treatment and attendance at scheduled sessions with parents. Before giving parents any information, we will discuss the matter with the minor if possible, and do our best to handle any objections he/she may have, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents (or other authorities) of our concern immediately and regardless of any objections the minor may have to us doing so.

## PARENTS, INFORMED CONSENT AND DIVORCE

If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, please note that our services fall under this, and you may be in violation of a court order if you fail to inform the other parent of our services with your child. Also note that to provide consent for treatment for your child you must either have sole custody or have shared legal custody, and if you have no legal custody you cannot provide consent for treatment. By signing below you are stating that you have the legal right to consent for this child. In the case of separation or divorce, any matter brought to our attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to our attention that are irrelevant to the child's welfare may be kept in confidence. However, these matters may best be brought to the attention of others, such as attorneys, personal therapist or counselors.

## CONTACTING YOUR THERAPIST

Please note that telephone calls are answered between **9:00 am - Noon** and **1:00 - 5:00 pm**, Monday through Friday. We are generally closed on Fridays during the summer months. Messages may be left on our voice mail system. We will make every effort to return your call on the same day you make it, or at least within 24 hours, with the exception of weekends and holidays. **ELECTRONIC COMMUNICATION, (EMAIL), PRESENTS A POTENTIAL RISK TO PATIENT CONFIDENTIALITY. Email is not a replacement for office visits.** While families and patients may find this a convenient way to communicate they must be aware of the risks. We will respond should you choose to email us regarding non-clinical issues such as appointment scheduling. **Please note we will not engage in "therapy" nor respond to casual "chats" via email. If you choose to share clinical information via email, we will bill for the time reading it and discussing it with you at your next therapy session or offer to schedule a phone consultation.** Clinically relevant information exchanged by fax/email may become a part of the clinical record.

## PATIENT CARE

New Horizons Wellness Services, LLC shall provide occupational and speech therapy services and materials in compliance with the orders of the patient's attending physician. Administration of treatments will be delivered as ordered by said physician.

- **Consent to Treatment:** Patient and/or patient representative acknowledge that the patient is under the medical treatment and care of said attending physician, and that New Horizons Wellness Services, LLC renders its services to the patient under the general and specific instructions of said physician. The patient and/or patient representative recognize that said physician furnishing services to the patient is an independent contractor and is not an employee or agent of New Horizons Wellness Services, LLC.
- **Restrictions and Liabilities:** New Horizons Wellness Services, LLC shall incur no liability for injuries of any kind suffered by the patient while under its care; therefore, should the patient discontinue treatment before the attending physician has so ordered, the patient and/or patient representative agrees to assume all responsibility for all results which may follow.
- New Horizons Wellness Services, LLC is not liable for injury to the patient caused by visitors attempting to assist or treat the patient in any way. For the safety of the patient and others, only the patient and the patient's guardian, if a minor, are permitted in patient treatment areas.
- New Horizons Wellness Services, LLC shall not be responsible for personal belongings left in the clinic.

## EMERGENCIES

We do not provide emergency services. In an emergency: contact your psychiatrist, pediatrician, primary care physician, call 911 or one of the local emergency services, go to the nearest hospital emergency room, and/or follow your insurance carrier's emergency procedures.

## OTHER CLINIC RULES

Children must be supervised at all times while in the clinic. It is the clinic policy that children who are not participating in therapy are not allowed in the gym or other treatment areas. Please supervise your children while they are in the waiting room area. We ask that you be courteous and respectful of others who are in the waiting room area.

## OCCUPATIONAL/SPEECH THERAPY OBSERVATIONS

You are welcome to observe your child's therapy session at any time. Please check with your therapist prior to the initiation of the treatment session. For adult patients, observation may or may not be appropriate by spouses or other family members. If you are not observing, you are welcome to wait in our waiting room area. If you need to leave the building for any reason, please make certain that your therapist and the front desk has a contact number where you can be reached in case of an emergency. **We ask that parents/transportation return 10 minutes prior to the end of the schedule session.** This will allow the therapist time to review your child's progress and answer any questions you may have. Other professionals are welcome to observe your child's therapy session. Please notify your child's therapist if you wish to set up an observation.

## SERVICE AGREEMENT

Your signature below indicates that you have read and understood this document and agree to abide by this agreement. Please ask for clarification of any information you are unclear about. By signing below you are also certifying that you have had the opportunity to review the HIPAA Notice of Privacy Practices and have been offered a copy to keep. You may revoke this agreement in writing at any time, and that revocation will be binding unless we have already taken action in reliance upon it.

_____

Patient's Name (Printed)

_____ _____

Signature of Patient (14 years+) Date

_____ _____

Signature of Personal Representative (if different) Date