PORTLAND DBT INSTITUTE, INC
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OREGON 97239
PHONE: (503) 231-7854 | FAX: (503) 231-8153

CLIENT INFORMATION SHEET

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

***Client Name**_____ **Legal Name, if different**_____
***DOB**_____ **SSN**_____ **Age**_____
Interpreter required? (*Mark one*): ____YES ___ NO If yes, language needed: _____
***Ethnicity** (*Mark one or write in*): ___ Hispanic ___Non-Hispanic ___Other: _____
***Race** (*Mark all that apply or write in*): ___Black or African-American ___American Indian or Alaska Native
___Native Hawaiian or Other Pacific Islander ___White ___Middle Eastern or North African ___Asian
___Other race or origin (*please list*):_____
***Gender Identity** (*Mark all that apply or write in*): ____Female ____Male ____Non-binary/3rd gender ____Two Spirit
____Other (*list*):_____ ____Prefer not to say
***Gender currently listed on insurance policy** (*Mark one*): __Female __Male [*Note: This is required for us to bill insurance*]
***Pronouns** (*Mark all that apply or write in*): ____She, her, hers ____He, him, his ____They, them, theirs
____Other (*list*):_____ **Sexual Orientation**_____ ***Marital Status**_____
***Military Status**_____ **Religion or spirituality**_____

***Home Address**_____ **City**_____ **State**_____ **Zip**_____
***Home/Cell Phone**_____ **Work Phone**_____ ***Can we leave a VM?** ___YES ___NO
Email Address_____ **Preferred contact method:** ___Phone ___Email

Job Title_____ **Employer**_____
Work Address_____
Work Phone _____ **Can we leave a voicemail?** ___YES ___NO
Other sources of income? (e.g. SSI, SSD, child support)_____

***Students*: Grade** _____ **School**_____ **School Counselor**_____
School Address_____ **Phone**_____

***Primary Physician**_____ **Date of last visit**_____ ☐No Primary Physician
Physician Address_____ **Phone**_____
***Emergency Medical Provider Name and Contact Number(s):**_____
_____
***Dental Provider Name and Contact Number(s):**_____
_____
Psychiatric Prescriber_____ **Date of last visit**_____ ☐No Psych. Prescriber
Prescriber Address_____ **Phone**_____

Who referred you to this office?_____
Address_____ **Phone**_____
Reason(s) for referral?_____
_____
_____

***Emergency Contact**_____ **Relationship to client**_____
***Address**_____
***Home/Cell Phone**_____ **Work Phone**_____

***If child or teen*: *Legal Guardian Name**_____ ***DOB**_____
SSN_____ ***Relationship to client** (*mark one*): ___Parent ___Other (*please specify*):_____
***Address**_____
***Home/Cell Phone**_____ **Work Phone**_____

Signature below of client or authorized person indicates: I authorize Portland DBT Institute to make contact with the referral source, physician, and/or prescriber for purposes of treatment planning and coordination of care.

_____ _____
Signature Date

_____
Printed Name

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INSURANCE INFORMATION FORM

INSTRUCTIONS: Please fill out this form entirely so we can accurately bill your insurance. This may require a call to your insurance plan for help with obtaining your benefits information (look for a Member Services or Customer Service phone number on the back of your insurance card). Additionally, please **attach a copy of EACH insurance card (front and back)**, or ask our Front Desk to make a copy for you. Electronic insurance cards can be securely uploaded on our website here: www.pdbti.org/secure-upload/

Important Primary and Secondary Insurance Disclaimer: As a courtesy, we will bill your primary insurance for services rendered. You will be required to pay the balance remaining after your primary insurance has paid. If your provider(s) at PDBTI are in-network with your secondary and/or tertiary insurance plans, we will bill them as well and you will be required to pay any remaining patient balance. We will not bill secondary and/ or tertiary plans where we are out-of-network, however we will be happy to provide you with a statement should you wish to recover your out-of-pocket expenses directly from your insurance plan.

Client Name: _____ Client DOB: _____

PRIMARY INSURANCE INFORMATION

Subscriber's Name_____ Subscriber DOB_____
Subscriber SSN_____ Relationship to client_____
Subscriber Address_____City_____State____ Zip_____
Phone: _____ Subscriber's employer_____

Primary Insurance Company Name: _____
Effective Date of Policy_____
Identification #_____ **Group #**_____
Claims Address_____City_____State_____ Zip_____
Member Customer Service Phone_____ Provider Cust. Serv. Phone_____

Is pre-authorization required for services at PDBTI? ____ Yes ____ No
Name/phone number of contact for obtaining pre-authorization_____
Deductible amount(s) $_____ Deductible met as of today? ____ Yes ____ No
If deductible not met, how much left? $_____
Any limits to mental health benefit? ___Yes ___ No If Yes: _____ sessions per year / $_____ per year

Signature below of client/authorized person indicates: Portland DBT Institute (PDBTI) has my permission to bill my insurance company. I authorize PDBTI to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to PDBTI. I understand that, additionally, the client will need to sign a Release of Information (ROI) form to consent to their records being shared with the insurance company to ensure compensation for services provided.

Printed Name:_____ Relation to Client:_____

Signature:_____ Date:_____

*(Please complete **other side** if you have additional insurance info!)*

INSURANCE INFORMATION FORM
(continued)

SECONDARY INSURANCE INFORMATION

Subscriber's Name_____ Subscriber DOB_____
Subscriber SSN_____ Relationship to client_____
Subscriber Address_____City_____State____ Zip_____
Phone: _____ Subscriber's employer_____

Secondary Insurance Company Name: _____
Effective Date of Policy_____
Identification #_____ **Group #**_____
Claims Address_____City_____State_____ Zip_____
Member Customer Service Phone_____ Provider Cust. Serv. Phone_____

Is pre-authorization required for services at PDBTI? ____ Yes ____ No
Name/phone number of contact for obtaining pre-authorization_____
Deductible amount(s) $_____ Deductible met as of today? ____ Yes ____ No
If deductible not met, how much left? $_____
Any limits to mental health benefit? ___Yes ___ No If Yes: _____ sessions per year / $_____ per year

TERTIARY INSURANCE INFORMATION

Subscriber's Name_____ Subscriber DOB_____
Subscriber SSN_____ Relationship to client_____
Subscriber Address_____City_____State____ Zip_____
Phone: _____ Subscriber's employer_____

Tertiary Insurance Company Name: _____
Effective Date of Policy_____
Identification #_____ **Group #**_____
Claims Address_____City_____State_____ Zip_____
Member Customer Service Phone_____ Provider Cust. Serv. Phone_____

Is pre-authorization required for services at PDBTI? ____ Yes ____ No
Name/phone number of contact for obtaining pre-authorization_____
Deductible amount(s) $_____ Deductible met as of today? ____ Yes ____ No
If deductible not met, how much left? $_____
Any limits to mental health benefit? ___Yes ___ No If Yes: _____ sessions per year / $_____ per year

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CLIENT'S RIGHTS AND RESPONSIBILITIES

Clients receiving treatment at the Portland DBT Institute have the right to:

(1) In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:
(a) Choose from services and supports that are consistent with the assessment and service plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for the greatest degree of independence;
(b) Be treated with dignity and respect;
(c) Participate in the development of a written service plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written service plan;
(d) Have all services explained, including expected outcomes and possible risks;
(e) Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50;
(f) Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:
(A) Under age 18 and lawfully married;
(B) Age 16 or older and legally emancipated by the court; or
(C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.
(g) Inspect their service record in accordance with ORS 179.505;
(h) Refuse participation in experimentation;
(i) Receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence;
(j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
(k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
(l) Have religious freedom;
(m) Be free from seclusion and restraint;
(n) Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;
(o) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented;
(p) Have family and guardian involvement in service planning and delivery;
(q) Have an opportunity to make a declaration for mental health treatment, when legally an adult;
(r) File grievances, including appealing decisions resulting from the grievance;
(s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
(t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
(u) Exercise all rights described in this rule without any form of reprisal or punishment.
(2) The provider shall give to the individual and, if appropriate, the guardian a document that describes the applicable individual's rights as follows:
(a) Information given to the individual shall be in written form or, upon request, in an alternative format or language appropriate to the individual's need;
(b) The rights and how to exercise them shall be explained to the individual, and if applicable the guardian; and
(c) Individual rights shall be posted in writing in a common area.

In addition, adult clients receiving treatment at the Portland DBT Institute have the responsibility to:

1. Be on time for appointments and call their therapist with 24 hours notice if there is a need to cancel.
2. Provide, to the extent possible, information that their therapist needs in order to provide psychological and other behavioral health services to you.
3. Participate, to the degree possible, in understanding their psychological/behavioral health condition and develop mutually agreed upon treatment goals.
4. Follow the plans and instructions for care that are agreed upon with their therapist.
5. Review their insurance benefit booklet or call their insurance customer relations representative to make sure services are covered under their plan and follow plan requirements to have services properly authorized.
6. Pay all agreed upon out-of-pocket charges and fees, as negotiated with their therapist and outlined in their treatment plan, providing such fees are in compliance with their insurance company contract.

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INFORMED CONSENT STATEMENT & OFFICE POLICY

The following statement answers some important and frequently asked questions concerning our program at Portland DBT Institute (PDBTI). If you have further questions after reading this, or other concerns not covered here, feel free to ask your therapist about them 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

After completing a mental health assessment, you will be provided information on service options. These include but are not limited to: 1) No treatment indicated, 2) treatment indicated but not with PDBTI (referrals provided if available), or 3) one or some combination of the following: individual therapy, family therapy, group therapy, and medication management. 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 including those pertaining to cultural competence, family involvement, and developmentally appropriate services 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. Psychiatric medication, if prescribed, can have side effects that may need monitoring or management. There are also benefits to treatment: Individuals participating in mental health treatment often learn skills to help cope with difficult emotions, change destructive patterns of thinking, improve interpersonal communication and demonstrate a positive impact overall behavior and personal wellness. DBT research finding regarding treatment benefits can be found on the Behavioral Tech, LLC website at www.behavioraltech.org or ask your therapist for information specific to PDBTI's treatment outcome research.

Complaints and Grievances

Any client who has a grievance arising from their treatment at PDBTI may present their grievance, verbally or in writing, to the Associate Director. The policy for the submission and review of complaints and grievances will accompany the intake paperwork. Grievance forms, as well as a notice listing contact information for oversight agencies can be easily accessed in the waiting room and/or by asking any PDBTI staff.

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. PDBTI staff consult together weekly about your treatment progress. If we need to consult outside our program, 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. Where 24-hour 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. Per OMAP requirements, OHP clients will not be assessed out-of-pocket charges including missed session fees and insurance past due amounts. Cancellations can be phoned into the office any time, day or night. Please be aware voicemail messages are date and time stamped. If you miss four consecutive sessions (no show or cancellation of scheduled individual or group sessions), regardless of the reason or notice given, you will be out of the program. You may reapply for services after what would have been your graduation from Phase I of the program (approximately a six-month period).

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, including weekends, and return calls as soon as possible. When your individual therapist is not available, he/she will leave a phone number where he/she can be reached or will arrange for substitute coverage. If you require emergency skills coaching, page your individual therapist immediately. He/she should return your call within the hour. If you are unable to reach your individual therapist, page your skills group leader, and if you are unable to reach your skills group leader, page your individual therapist's supervisor. If you are unable to reach these PDBTI contacts, call the Crisis Line at 503-988-4888 (Multnomah County), 503-291-9111 (Washington County), 503-655-8401 (Clackamas County), or 503-585-4949 (Marion County), or go to the nearest hospital emergency room.

Safety Policy

Portland DBT 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 a program manager and/or 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 PDBTI services. Please note that minors (children under 18 years old) must be accompanied by a responsible adult at all times while on PDBTI premises and that it is the adult's 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 PDBTI's financial policies and procedures. We require that you inform

us immediately of any change in your insurance plan or benefit coverage, including OHP. If for any reason, your insurance does not cover services rendered, you are responsible for your bill. If you have questions about your insurance benefit coverage it is your responsibility to contact your insurance company for information and clarification.

As a client participating in comprehensive DBT treatment or EST (Enhanced Skills Training), you are also considered a "member". The membership cost of $75.00 is a required fee essential to offset the cost of DBT services and materials that are not reimbursed by commercial insurance. This fee will not be charged until you have committed to treatment at PDBTI and will be collected upon registration for group. As with any outstanding balance, you will receive a statement reflecting this charge until it is paid in full. Clients with the Oregon Health Plan and Kaiser HMO do not have to pay the membership fee as a benefit of their plan coverage.

Data Collection Permissions

We are continually seeking to improve our services and give back to the field. For these reasons, we would like your permission to use your data for research purposes. Any research done will be done without any identifying information, data and results using your information will be kept completely anonymous. Data collection will take the form of surveys and questionnaires.

PDBTI 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

_____ _____

Client Signature **Date**

_____ _____

Witness Date

I have reviewed the posted HIPAA privacy act and a copy has been made available to me. _____**Initial**

I have reviewed the posted Declaration for Mental Health Treatment and a copy has been made available to me. _____**Initial**

I have reviewed the posted Summary of Service Delivery Policies and Procedures and a copy is available to me. _____**Initial**

I have been offered a voter registration card. _____**Initial**

I have received a copy of the Client Rights and Responsibilities and have had my rights fully explained and my questions answered. _____**Initial**

I have been offered the complaint and grievance policy and a copy of the grievance form. _____**Initial**

_____

Client Printed Name

_____ _____

Client Signature **Date**

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TELEHEALTH INFORMED CONSENT STATEMENT & OFFICE POLICY

The following statement answers some important and frequently asked questions concerning our use of telehealth services at Portland DBT Institute (PDBTI). In order to maintain care under certain circumstances, including during periods of office closure for any reason, PDBTI may offer to conduct individual sessions, group sessions, and assessments via telehealth service. Telehealth service is the delivery of healthcare services when the therapist and patient are not in the same physical location/site through the use of various technology. This could include video sessions via telehealth software on a computer or tablet, or phone sessions.

Risks and Benefits of Telehealth Sessions

Generally speaking, the risks and benefits of telehealth are similar to those of in-person sessions. There are additional risks, however. First, although we will use secure platforms (e.g., Zoom) with industry-standard encryption and security, there is no way to guarantee that this software is completely failure-proof. As with any technology, there is a chance of a security breach that would affect the privacy of personal and/or medical information. Second, since you will be completing sessions in your own home, we cannot guarantee the same level of privacy that you have when you are in our clinic. This means that you are responsible for making sure that you are in a private area where disruptions (e.g., others coming into the room or hearing what you say in another room) are minimized as much as possible. Third, in the event of group sessions conducted via video, it is possible that your confidentiality could be breached if others in the group are not in a confidential setting.

In order to reduce risks to confidentiality, we suggest that all video or telephone sessions occur in a private room with no one else present and that you wear headphones to limit the possibility of other people overhearing confidential information. In group video sessions, you have the option to turn off your camera so that others may not see you.

Since this may be different than the type of sessions with which you are familiar, it is important that you understand, acknowledge, and agree to the following statements:

- You understand that you have undertaken to engage in a telehealth encounter for yourself that will contain personal identifying information as well as protected health information
- You understand that the therapist/assessor will be at a different location from you.
- You understand that you have the right to withhold or withdraw your consent to the use of telehealth services at any time in the course of your care, without affecting your right to future care or treatment.

- You have been informed of and accept the potential risks associated with telehealth, such as failure of security protocols that may cause a breach of privacy of personal and/or medical information.
- You understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies you will be disclosed to other entities without your consent or as may be allowed by law.
- You have been given the opportunity to ask your provider at PDBTI questions relative to your Telehealth encounter, security practices, technical specifications, and other related risks.

By signing this form, you certify:

- That you have read or had read and/or had this form explained to you;
- That you fully understand its contents including the risks and benefits of telehealth services;

  and

- That you have been given ample opportunity to ask questions and that any questions have been answered to your satisfaction.

_____ _____

Signature of Client **Date**

_____

Printed Name of Client

_____ _____

Signature of Person Obtaining Consent **Date**

_____

Name of Person Obtaining Consent

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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 Portland DBT Institute (PDBTI) 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

PDBTI 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. PDBTI 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 emails/texts 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.
f) Appointment reminders via email or text message can only be done after the patient consents to receiving such messages, in compliance with the Telephone Consumer Protection Act (TCPA).

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 PDBTI and me, and consent to the conditions and instructions outlined, as well as any other instructions that the PDBTI 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 automated appointment reminders…

via e-mail? ____Yes ____No
via text (SMS)? ____Yes ____ No
via voicemail? ____ Yes ____ No

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FINANCIAL POLICY

In the interest of a cooperative working relationship between Portland DBTI 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.
Note: If client is not a minor and has someone else who is financially responsible for them (i.e. guarantor), the guarantor should complete and sign the GUARANTOR POLICY instead.

Client Membership Fees and Out- of -Pocket Expenses:
Client out-of-pocket expenses such as membership fees, deductibles, co-payments, and co-insurances are due at the time of service. All clients in EST or comprehensive DBT treatment are considered members of our program. The membership fee is due at the time of group registration. Clients with the Oregon Health Plan or Kaiser HMO plans are not required to pay the membership fee as a benefit of their coverage. A credit card authorization form must be signed prior to treatment for all outstanding balances (clients with OHP coverage are excluded from this requirement).
Initial_____

Insurance Billing: As a courtesy to clients, we will bill your primary insurance for services rendered providing you submit all the necessary information enabling us to do so. You will be required to pay the balance remaining after your primary insurance has paid. Please be aware that no-show/late cancellation fees and parent skills group sessions are not billed to insurance and are due by the client on or before your next scheduled appointment.

Secondary Insurance: If your provider(s) at PDBTI are in-network with your secondary and/or tertiary insurance plans, we will bill them as well and you will be required to pay any remaining patient balance. We will not bill secondary and/ or tertiary plans where we are out-of-network, however we will be happy to provide you with a statement should you wish to recover your out-of-pocket expenses directly from your insurance plan.

Insurance Delinquent Balances: We consider it our responsibility to provide clients and their families with quality care. In exchange, we ask that clients work with their insurance companies to compensate us in a timely manner for services rendered. While we do our best to collect on all insurance claims, in the end, we cannot accept responsibility for continued follow up on past due claims or negotiating a disputed claim. Thus, we require that insurance balances past due by 90 days and/or equal to or greater then $2000.00 be paid by the client in full in order to continue services. Clients in the Eating Disorder Intensive Outpatient Program (ED IOP) may not have an outstanding insurance balance over $9000.00 (22 days of services). You will be given adequate notice and referral options should your treatment at PDBTI be postponed until delinquent insurance balances have been resolved.
Initial_____

Client Delinquent Balances: Client balances (not owing by insurance) 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 PDBTI 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 come back to the program until your balance has been paid in full. Further, if you name PDBTI as a debtor when filing bankruptcy you will not be able to return for services.
Initial_____

Client Refunds: Client refunds are issued the 15th of every month once your account has been cleared. In other words, even if you have money on account, refunds will not be issued until after your insurance has paid in full.

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 others 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.

OHP Clients: Per OMAP requirements, OHP clients will not be assessed out-of-pocket charges including missed session fees and insurance past due amounts. However, if an OHP client's insurance balance is past due by 90 days and/or is equal to or greater than $2000.00 ($9000.00 for ED IOP services), treatment may be interrupted until the insurance problem has been resolved.

Signature below indicates 1) I have read Portland DBTI's financial policy, 2) I understand Portland DBTI's financial policy, and 3) I agree to Portland DBTI's financial policy.

Name: _____ Relation to Client: _____

Signature: _____ Date: _____

PORTLAND DBT INSTITUTE, INC
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OREGON 97239
PHONE: (503) 231-7854 | FAX: (503) 231-8153

AUTHORIZATION OF 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 Portland DBT Institute, Inc to charge the credit
(cardholder name)
card as named above for health services rendered to _____.
(client full 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
- Parent Group
- Med Management
- Nutrition Management
- Case Management Services
- Intensive Outpatient Services
- Consultation
- Missed Session
- Co-pay
- Deductible

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

PORTLAND DBT INSTITUTE, INC
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OREGON 97239
PHONE: (503) 231-7854 | FAX: (503) 231-8153

GUARANTOR POLICY

Client Name: _____
Person and/or Agency Financially Responsible (i.e. Guarantor): _____
Guarantor DOB: _____ Guarantor SSN/Tax ID: _____
Billing Address: _____ City/State: _____ Zip: _____
Phone Number: _____

I, _____ by signing below, acknowledge that health care services provided by Portland DBTI for the above named client will be covered by the insurance company/payor known as _____. As a member and/ or designated representative of this company, I/we agree to the following financial policy:

In the interest of a cooperative working relationship between Portland DBTI, clients, and payors, please carefully read our financial policy as described below. If you have any questions or concerns regarding this policy, we encourage you to speak with the client's therapist.

Client Membership Fees and Out- of -Pocket Expenses:
Client out-of-pocket expenses such as membership fees, deductibles, co-payments, and co-insurances are due at the time of service. All clients in EST or comprehensive DBT treatment are considered members of our program. The membership fee is due at the time of group registration. Clients with the Oregon Health Plan or Kaiser HMO plans are not required to pay the membership fee as a benefit of their coverage. A credit card authorization form must be signed prior to treatment for all outstanding balances (clients with OHP coverage are excluded from this requirement).
Initial_____

Insurance Billing: As a courtesy to clients, we will bill your primary insurance for services rendered providing you submit all the necessary information enabling us to do so. You will be required to pay the balance remaining after your primary insurance has paid. Please be aware that no-show/late cancellation fees and parent skills group sessions are not billed to insurance and are due by the client on or before your next scheduled appointment.

Secondary Insurance: If your provider(s) at PDBTI are in-network with your secondary and/or tertiary insurance plans, we will bill them as well and you will be required to pay any remaining patient balance. We will not bill secondary and/ or tertiary plans where we are out-of-network, however we will be happy to provide you with a statement should you wish to recover your out-of-pocket expenses directly from your insurance plan.

Insurance Delinquent Balances: We consider it our responsibility to provide clients and their families with quality care. In exchange, we ask that clients work with their insurance companies to compensate us in a timely manner for services rendered. While we do our best to collect on all insurance claims, in the end, we cannot accept responsibility for continued follow up on past due claims or negotiating a disputed claim. Thus, we require that insurance balances past due by 90 days and/or equal to or greater then $2000.00 be paid by the client in full in order to continue services. Clients in the Eating Disorder Intensive Outpatient Program (ED IOP) may not have an outstanding insurance balance over $9000.00 (22 days of services). You will be given adequate notice and referral options should your treatment at PDBTI be postponed until delinquent insurance balances have been resolved.
Initial_____

Client Delinquent Balances: Client balances (not owing by insurance) 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 PDBTI 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 come back to the program until your balance has been paid in full. Further, if you name PDBTI as a debtor when filing bankruptcy you will not be able to return for services.

Initial_____

Client Refunds: Client refunds are issued the 15th of every month once your account has been cleared. In other words, even if you have money on account, refunds will not be issued until after your insurance has paid in full.

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 others 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.

OHP Clients: Per OMAP requirements, OHP clients will not be assessed out-of-pocket charges including missed session fees and insurance past due amounts. However, if an OHP client's insurance balance is past due by 90 days and/or is equal to or greater then $2000.00 ($9000.00 for ED IOP services), treatment may be interrupted until the insurance problem has been resolved.

Signature below indicates 1) I have read Portland DBTI's financial policy, 2) I understand Portland DBTI's financial policy, and 3) I agree to Portland DBTI's financial policy.

Financially Responsible Party:

Name: _____ Relation to Client: _____

Signature: _____ Date: _____

PORTLAND DBT INSTITUTE, INC
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OREGON 97239
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CLIENT SELF-REPORT FORM

Client Name (print): _____ **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	☐	Hypervigilance
☐	Sleep difficulties	☐	Obsessive thoughts	☐	Irritability/anger	☐	Flashbacks
☐	Change in appetite	☐	Social discomfort	☐	Aggression	☐	Avoidance of certain people, places, situations
☐	Loss of pleasure	☐	Suspicion/paranoia	☐	Frequent arguments	☐	Increased startle response
☐	Crying spells	☐	Visual hallucinations	☐	Sexual problems	☐	Feeling detached/unreal
☐	Seasonal mood changes	☐	Racing thoughts	☐	Computer addiction	☐	Losing time/dissociation
☐	Thoughts of death	☐	Hearing voices	☐	Relationship problems	☐	Wide mood swings
☐	Low self-worth	☐	Poor memory/concentration	☐	Problems with pornography	☐	Excessive energy
☐	Fatigue	☐	Homicidal thoughts	☐	Gambling problems	☐	Alcohol/drug abuse
☐	Withdrawal from people	☐	Self-harm	☐	Work/school problems	☐	Other:
☐	Guilt/shame	☐	Loneliness	☐	Eating problems		
☐	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

Please check any current stressors you are experiencing and <u>feel comfortable sharing</u>:

☐Finances/Poverty	☐Unstable housing	☐Discrimination
☐ Unemployment/Difficulty finding employment	☐ Issues related to immigration or refugee status	☐ Issues related to a disability/being differently abled

Is there anything you would like to add regarding the stressors checked above?

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: ☐ **Yes trauma** ☐ **No trauma**
Note: Opportunity to include additional comments about trauma will be addressed in session.

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?

Portland DBT Institute, Inc.
5200 SW Macadam Ave, Suite 580
Portland, OR 97239
Phone: 503-231-7854
Fax: 503-231-8153

PDBTI Therapist Name:
_____

Please mark as applicable:
_____ PDBTI is **SENDING Records** to Named Party
_____ Keep Release **ON FILE** for Future Use
_____ PDBTI is **REQUESTING Records** from Named Party

EMERGENCY CONTACT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

A. By signing this form, I, (client's full name) _____, authorize **Portland DBT Institute, Inc.** the use and disclosure of my individually identifiable health information to/from the following emergency contact:

_____ _____
Full Name of Emergency Contact | Relationship to Client

_____
Address of Emergency Contact | Phone Number of Emergency Contact

B. Purpose of Disclosure: In the event of a medical emergency (i.e. a condition which poses an immediate threat to the health of the individual and which requires immediate medical intervention). In such an event, my health information, which is specifically protected under federal law, may be disclosed to the above named Emergency Contact by Portland DBT Institute, Inc.

C. Specific Information to be Disclosed: By **initialing** below, I specifically authorize the use and disclosure of the following confidential information: (*Please write your **INITIALS** below by each selected category.*)

_____ Psychiatric and Mental Health information as included in the records
_____ Substance Use Disorder (SUD)/Alcohol and Drug Treatment information (Specifically protected under law), *except for* the following (if no exceptions, leave blank): _____
_____ 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*: _____

D. I give permission to release my records from the following dates (*Note*: this is a required section):

_____ _____
(approximate **start date** of treatment from provider) | (approximate **end date** of treatment from provider)

E. I understand that my records are protected under the federal and state confidentiality regulation, including HIPAA, 42 CFR Part 2, 45 CFR Parts 160 and 164, 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 Portland DBT Institute.

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: _____
Client's Full Name (Print):_____
Client's Date of Birth: _____ Client's 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: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Portland DBT Institute, Inc
5200 SW Macadam Ave, Suite 580
Portland, OR 97239
Voice: 503-231-7854 Fax: 503-231-8153

Therapist: _____

___ DBTI is **SENDING** Records
___ Keep Release on **FILE** for Future Use
___ DBTI 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 Portland DBTI

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 Portland Dialectical Behavior Therapy Institute.

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: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.