December 2013

Ann Marie Miner, Psy.D.
Licensed Clinical Psychologist
516 SE Morrison Suite 1010
Portland, OR 97214
503-610-3436
ccanorthwest@gmail.com
www.annmarieminerpsyd.com

OFFICE POLICIES AND INFORMATION

OFFICE HOURS AND APPOINTMENTS: I am typically in the office Monday through Friday with varying hours. Please leave me a message at **503-610-3436** to set up or change appointments or leave non-emergency messages. You are also welcome to email me at ccanorthwest@gmail.com for non-emergency and scheduling related message.

EMERGENCIES: If you have a medical emergency or are in immediate danger, please call 911, go to your nearest hospital emergency department or call your primary care doctor. If you are in a mental health crisis and/or in danger of harming yourself or others and need immediate assistance, please call the Multnomah County Crisis Line at **503.988.4888**.

In the case of my death or incapacity, Pamela Sheffield, PsyD 503-290-3279 will maintain records and facilitate referrals or transfers.

FEES, BILLING AND PAYMENTS: A copy of the fee schedule is available on my website. When you complete the questionnaire I've sent to you before our first session, you will also choose a credit or debit card to establish a secured account. You can elect to use this card to pay for your sessions or choose another format. You may pay by cash or check in session for the portion of my fee for which you are responsible. You can also be billed monthly for your total balance; I will do this using the card provided to establish your account. The card you use to establish your secured account will be charged at the end of each month if payment has not been otherwise arranged.

Please check with your insurance company before our first session to inquire about your coverage as you will be responsible for providing payment in session no matter your insurance coverage. Some companies pay the same amount for "in network" or "out of network" providers, others reimburse a lesser amount for out of network providers. It is important that you verify with me whether I am in network or out of network with your insurance company in order to obtain accurate information when you call them.

I will submit claims to your insurance company on your behalf. As outlined in the NOTICE OF PRIVACY PRACTICES below, a portion of your Protected Health Information (PHI) will be used to submit claims. While it is important to check your benefits ahead of time, quoted benefits over the phone are not a guarantee of payment. You are responsible for the portion of my fees which are not covered by your insurance policy.

CANCELLATION POLICY: Please give **24 hours** notice for cancellation of appointments; leaving a voicemail or sending an email within that timeframe is sufficient and I will get back to you as soon as I am able to reschedule your appointment. Your account will be charged my full fee for appointments that are not cancelled within 24 hours of your scheduled time. This fee is **not** reimbursed by your insurance company. I will leave a **15 minute** window if you are late for your scheduled appointment; please call to let me know if you are late. After 15 minutes, your session will be cancelled and you will be charged my full fee for the session. This is **not** reimbursed by your insurance company.

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PHONE CALLS AND CONSULTATIONS: If phone calls are longer than 5 minutes, I reserve the right to charge in accordance with my usual fees. I may also charge for necessary consultation on your behalf, including school consultations, contacts with physicians, referrals to other services, or report writing. Note that these services are typically **not** covered by insurance so you will be responsible for full payment at time of service.

TREATMENT: After evaluating your needs, an informal treatment plan will be developed collaboratively with you. *You need to be aware that clients can often feel worse before they start to feel better in therapy, and changes made by clients may disrupt the status quo of current relationships.* If effective alternate treatments are available, these will be discussed. Psychological tests or questionnaires may be used to help with diagnosis, treatment planning, and evaluation of therapy effectiveness. Please feel free to discuss any questions or concerns that you may have throughout the course of therapy. You have a right to request treatment changes or to refuse treatment at any time. If you feel that the match with this psychologist is not working well for you, I will be happy to help you make the transition to another therapist in a way that keeps your best care top priority. Note that by agreeing to provide treatment for you, I am not agreeing to provide legal opinions, testimony about your condition, disability evaluations or evaluations for worker's compensation claims.

NOTICE OF PRIVACY PRACTICES

Ann Marie Miner, Psy.D. is committed to preserving the privacy of your Protected Health Information (PHI). In fact, as a Psychologist, I am required by law to protect the privacy of your PHI as much as possible and to provide you with Notice describing:

HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

- The law permits me to share your PHI, as needed, for the purposes of arranging for reimbursement for my services, to consult with and coordinate your health care with other health care providers, and for related administrative activities supporting your treatment or billing.

- I may be required or permitted by certain laws to use and disclose your PHI for other purposes without your consent or authorization, such as but not limited to situations: 1) involving imminent risk of significant harm to yourself or others, 2) involving abuse of a minor, elder, developmentally disabled or chronically mentally ill person, 3) involving a court of law ordering an evaluation or treatment, 4) involving a court subpoena for release of PHI, 5) involving request of a parent if client is a minor, 6) possible changes relative to confidentiality in couples or family therapy, 7) if a complaint or lawsuit is filed against me, 8) if a threat or crime is committed against me.

- If a third party requests treatment or evaluation (e.g. the Court, your attorney, DDS, etc.) this requester is often considered the "client" and the holder of the confidentiality privilege. In that case, your PHI records would be released to this requester rather than to you personally. You may ask the third-party requester for a copy of your records.

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- Parents have a legal right to their children's PHI records and custodial and non-custodial parents have equal access. Exceptions would be any parent whose parental rights have been terminated, situations of abuse (or alleged abuse) of the child by the parent or through the parent's neglect, or clinical assessment that the sharing of the child client's PHI records with the parent would constitute an imminent high risk of significant injury to the child client. If you are a parent bringing your child in for treatment or evaluation, I will likely ask you to allow the child some privacy regarding their PHI record as a part of developing greater emotional safety for the child in the therapeutic process.

- There are often additional limits to confidentiality when working with couples or families. This will be discussed on a case-to-case basis.

- As a client, you have important rights relating to inspecting and copying your PHI that I maintain, amending or correcting that information, obtaining an accounting of my disclosures of your PHI, requesting that I communicate with you confidentially, requesting that I restrict certain uses and disclosures of your PHI and complaining if you think your rights have been violated.

- I have available in the waiting area, a more detailed NOTICE OF PRIVACY PRACTICES which more fully explains your rights and my obligations under the law. I may revise my NOTICE from time to time. The Effective Date at the top right of this page indicates the date of the most current NOTICE in effect. You have a right to receive a copy.

- If you have any questions, concerns or complaints about the NOTICE OF PRIVACY PRACTICES, please let me know.

I agree to psychological treatment with Ann Marie Miner, Psy.D. I have read and fully understand this disclosure statement and have been given the opportunity to ask questions. Both parties agree to abide by these terms of treatment. My consent shall be in effect for the duration of treatment.

_____

Signature of Client or Legal Representative Date

_____

Ann Marie Miner, Psy.D. Date
Licensed Clinical Psychologist
Oregon License Number: 2131
Washington License Number: PY60251180

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CLIENT/ INSURANCE INFORMATION

First Name Middle Initial Last Name Date of Birth

Your Address _____

Phone #s _____ Can I leave a message on this number? Y____ N____

Emergency Contact (Name and Phone): _____

Primary Care Physician (Name and Phone): _____

Name of primary insured member:_____ **Their DOB:** _____

Primary Insurance Company:_____ ID#: _____ Group#: _____

Phone Number on Insurance Card: _____

Address of Primary Insured
Member:_____

Name of secondary insured member:_____ **Their DOB:** _____

Secondary Insurance Company: _____ ID#: _____ Group#: _____

Phone Number on Secondary Insurance Card: _____

Address of Secondary Insured Member:_____

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INFORMED CONSENT FOR TREATMENT

Your Protected Health Information (PHI) is kept under the strictest rules of confidentiality and typically requires your signature of consent before releasing PHI. However, as noted earlier in the NOTICE OF PRIVACY PRACTICES and OFFICE POLICIES, rules of confidentiality may be broken under certain circumstances as mandated or permitted by law. It is my usual practice that your PHI will be received from or released to other health care providers as needed to make decisions and improve your care and treatment, but only if you sign a release to authorize me to do so. Signing this form indicates your agreement for me to share limited PHI as needed to bill your insurance companies (or other payers) to determine eligibility for health plan insurance coverage, to request authorizations, to submit claims to request payment, and for related administrative activities.

My signature below indicates that I have received, read and understood this Consent form, the NOTICE OF PRIVACY PRACTICES form and the OFFICE POLICIES form, and that I am authorizing Ann Marie Miner, PsyD, to use and disclose PHI about me as outlined. My signature also indicates that: 1) I am requesting mental health treatment and/or assessment from Ann Marie Miner, PsyD, 2) I accept responsibility for payment of non-insurance covered charges (phone calls, consultations, etc), and, 3) I understand that I can revoke this consent at any time, and do to so, I must submit a request in writing to Ann Marie Miner, PsyD at 516 SE Morrison St. Suite 1010, Portland, OR 97214.

_____

Signature of Client or Legal Representative Date

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CARD AUTHORIZATION

Card Type: _____

Name on Card: _____

Card Number: _____

Expiration Date: _____ 3-Digit (CCV) on Back: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address of Card Owner: _____

Phone Number of Card Owner: _____

It is your choice whether or not to regularly use this card to pay your account balance at the end of each month. You may also pay via the website prior to your visit, or with cash or check at the time of your visit. If payment has not been received within three days of the end of the month, I will charge this card to keep your account up to date. Please keep in mind that you are responsible for any costs that your insurance does not cover, including no-show or late cancellation fees.

Signature Date:

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CLIENT QUESTIONNAIRE

Please answer these questions and bring this form to your first visit. If you are unable or prefer not to answer some of these questions, we will discuss them at your first visit.

Client Name _____ Date _____
Race/Ethnic Group _____ Gender _____
Relationship Status: _____ Age: _____

*list name and relationship of person filling out this form if other than the client- then answer the questions *about the client.*

How were you referred? _____

What aspects of your life bring you joy (of any degree)?

What is most important to you in your life right now?

What do you think is getting in the way of your quality of life?

What are your greatest strengths?

What are your main reasons for seeking psychotherapy at this time?

Who is your primary care provider?_____ Date of last medical exam: _____

Do you see any alternative care providers?

What type of work do you do? If you don't work, how are you financially supported?

What is your highest level of education? Do you have any learning problems? Explain:

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Have you (or family) ever been arrested? Yes ___ No ___Explain:

Where were you born and where did you grow up?

Briefly describe your childhood (we'll talk more about this in session):

Have you been in therapy before? Are you aware of any past diagnoses you have been given?

Do you have any relatives with mental health issues? Explain:

Do you have any thoughts of harming yourself? Yes___ No___
Have you harmed or tried to kill self? Yes____ No___

Do you have any thoughts of harming others? Yes___ No___
Have you harmed others? Yes___ No___

Have any family members ever attempted suicide? Yes___ No___
Explain if yes:

Have you ever been physically abused? Yes___ No___

Have you ever been sexually abused? Yes___ No___

Have you ever been verbally/emotionally abuse? Yes___ No___

Have you ever been hospitalized for psychiatric reasons? Yes___ No___
Explain if yes:

Over the past two months, have you been experiencing any of the following? **Rate** intensity on a scale of 1-10, with 1 being "barely at all" and 10 being "it could hardly be worse."

1-10
____ Over-sleep
____ Difficulty Sleeping

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____ Low appetite
____ Unintended weight loss or gain
____ Eat too much
____ Restricting ____ binge eating ____ purging____
____ Depressed mood
____ Sadness
____ Tearfulness
____ Loss of interest or pleasure in usually pleasurable activities
____ Loss of sexual interest
____ Problems with sexual functioning
____ Feeling guilty
____ Feeling worthless
____ Feeling helpless
____ Feeling hopeless
____ Internal sense of irritability or anger
____ External anger out-bursts and/or aggression
____ Feeling emotionally numb
____ Fatigue or lack of energy
____ Extended times of being unusually elated or emotionally/physically "hyper"
____ Cycles of several days of significantly little sleep (How much sleep/day:
____ Cycles of several days of significant increase in activity, but difficulty staying organized
____ Cycles of several days of significant increase in risk taking (over-spending, risky sex, other)
____ Cycles of several days of overly high energy with euphoria or intense anger
____ Impulsive behavior
____ Poor judgment
____ Feeling that thoughts are racing
____ Difficulty with focus or concentration
____ Start tasks but have difficulty completing them
____ Memory problems: Recent events : __yes __no; Past events : __yes __no; Plans : __yes __no
____ Difficulty with new learning
____ Anxiety/Nervousness
____ Worrying about everything all the time
____ Muscle tension or pain
____ Exposure to a significantly traumatic incident or history of long-term trauma
____ Inability to recall important aspects of trauma
____ Intrusive thoughts or images that you wish would go away?
____ Nightmares
____ Avoidance of people or places for fear of having traumatic memories triggered
____ Avoidance of people or places for fear of being embarrassed
____ Avoidance of people or places for fear of having a panic attack
____ Significant feelings of distress if unable to avoid or if you make self endure above?
____ Jumpy/Easily startled
____ Frequently feel "on guard", plan escape routes, vigilantly scan environment for danger
____ Feelings of detachment or estrangement from others
____ Difficulty having loving, happy or contented feelings

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____ Sense that you don't expect to have a normal lifespan
____ Ritualistic compulsive behaviors (Eg: checking, counting, stepping over cracks, other)
____ Thoughts that something bad will happen if you don't do the ritual
____ Panic attacks
____ Anxiety about being in situations in which escape may be difficult/embarrassing
____ Avoidance of such situations
____ Anxiety in social situations (Eg: meeting new people, being center of attention, public speaking)

Do you have other symptoms for which you are hoping to get help? **Explain**:

Do you use or have a history of use of the following?

History of Use		**Age started using**	**Amount of current use**
__Yes	__No Caffeine		
__Yes	__No Nicotine		
__Yes	__No Alcohol		
__Yes	__No Marijuana		
__Yes	__No Heroin or other opiates		
__Yes	__No Methamphetamines or other stimulants		
__Yes	__No Abuse of prescriptions drugs		
__Yes	__No Other (Please specify):		

Have you ever felt you ought to cut down on your drinking or drug use? __Yes __No
Have people annoyed you by criticizing your alcohol or drug use? __Yes __No
Have you felt bad or guilty about your drinking or drug use? __Yes __No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover or to get the day started? __Yes __No
Has the use of alcohol or drugs ever interfered in your life or relationships? __Yes __No
Have you been in drug or alcohol treatment? When? **Explain if yes*:*** __Yes __No

Do you have a history of head injury? Did you lose consciousness?

Please list **ALL** medications you are taking **currently**, with **dosages** and **date started**

Name	Dosage	Approximate Date Started
1.		
2.		
3.		
4.		
5.		
6.		