STEVEN W. SPOTTS, PSY.D.
LICENSED PSYCHOLOGIST

4900 S.W. GRIFFITH DR., SUITE 265 • BEAVERTON, OR 97005
(503) 526-9304 FAX: 627-9145 E-MAIL: PSYHUB@MAC.COM

*WELCOME! PLEASE TAKE TIME TO READ THE STATEMENT OF "**OFFICE POLICIES**" AND "**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**" CAREFULLY. THEN FILL IN THE REMAINING **CLIENT REGISTRATION** AND **PERSONAL INFORMATION SHEET** AS FULLY AS POSSIBLE. BOTH THE **CONSENT AND REGISTRATION FORM**S NEED TO BE SIGNED BEFORE WE CAN BEGIN OUR WORK. IF SOMETHING DOESN'T APPLY TO YOU, YOU MAY LEAVE IT BLANK.YOUR PAPERWORK WILL BE REVIEWED DURING YOUR FIRST APPOINTMENT.*

IF YOU HAVE QUESTIONS REGARDING THE PAPERWORK, FEEL FREE TO ASK THEM AT THAT TIME.

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Office Policies

APPOINTMENTS

- All services are provided by appointment. During your initial session, we will discuss your scheduling needs and options for any continuing work. Individual appointments are 53-60 minutes in length and typically begin on the half hour.
- In case of illness or other need for cancellation please leave a message at the phone number for this office listed above. Messages can be left on my voice-mail or e-mail systems 24 hours a day.

EMERGENCIES

- If you experience an emergency and need to talk to someone immediately, please call my office and follow the instructions on my voice mail regarding emergencies.
- If I am unable to return your call at that time, you will be advised to call the Washington County Mental Health Crisis Line (291-9111), your physician; or to seek help at the emergency room of a local hospital.

CONFIDENTIALITY

- Your right for the strictest confidence possible within the provisions of Oregon law is protected in our work together. If additional information is needed, such as medical records, you will be asked to sign a form entitled "Request and Authorization to Use and Disclose Protected Health Information." Likewise, if another agency or person requests information from this office concerning you, it will only be released if you have signed a HIPAA compliant statement requesting its release. Please read the "Notice of Privacy Practices" provided for you by my office for further information regarding how your medical information may be used or disclosed.
- Exceptions to confidentiality in Oregon law primarily involve those instances in which a client is perceived to be a danger to self or to others; or in certain legal matters where you must waive your privilege to keep your records confidential. In these rare cases this office may be required by law to report information regarding you without your consent. *Please Note: You are encouraged to discuss with me any concerns you may have about the limits of confidentiality before revealing information to me you wish to keep private.*

FINANCIAL ISSUES

- The current fee is $140 per 53-60 minute session or $125 for a 38-45 minute session. A full fee may be charged if you fail to meet a scheduled appointment without 24-hour advance notice. *Please Note: Insurance will not pay for missed sessions.*
- Additional services required outside of regular office sessions may be charged accordingly. These may include extended phone calls, testing, written evaluations, school conferences, or planning with other professionals. Fees for these services are based on my standard hourly rate.
- Payment of fees (including patient co-pays) is expected at the time services are rendered unless other arrangements are made. If unpaid balances accrue, an interest rate up to 2% per month may be charged. *Please note: Delinquent accounts will be handled by an outside collection agency or through other legal processes.*
- Our billing office will file insurance claims electronically. Statements will be mailed or given to you monthly in the event of an unpaid balance. Even though an insurance claim is filed, you will receive a statement if your account has a balance due. Please use these to ensure accuracy and to track your fees, adjustments, and payments.
- This office cannot accept responsibility for collecting on a disputed insurance claim. You hold final responsibility for payment of your account. If you have questions at any time about your bill, please feel free to call me and discuss your concerns.

IMPORTANT NOTE

- Please make sure the following forms are completed. 1) Client Registration Form; 2) Consent for Purposes of Treatment, Payment and Health Care Operations; and, 3) Personal Information Sheet. Sign the consents on forms 1 & 2 after careful review of these office policies. Your signatures confirm that you understand and agree to these policies and that you consent to begin treatment with Dr. Spotts. If you are using your health insurance, please also sign the "release of information" and "authorization to pay provider" (Lines 12 & 13) on the red HCFA claim form.
- It is important to keep this office informed of any changes in the information you are providing.

- ***Please Keep This Information Sheet For Future Reference***

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I CONSENT TO THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY DR. STEVEN W. SPOTTS FOR THE PURPOSE OF DIAGNOSING OR PROVIDING TREATMENT TO ME, OBTAINING PAYMENT FOR MY HEALTH CARE BILLS OR TO CONDUCT THE HEALTH CARE OPERATIONS OF HIS OFFICE.

I UNDERSTAND THAT DIAGNOSIS OR TREATMENT OF ME BY DR. SPOTTS MAY BE CONDITIONED UPON MY CONSENT AS EVIDENCED BY MY SIGNATURE ON THIS DOCUMENT.

I UNDERSTAND I HAVE THE RIGHT TO REQUEST A RESTRICTION AS TO HOW MY PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS OF THE PRACTICE. DR. SPOTTS IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS THAT I MAY REQUEST. HOWEVER, IF HE AGREES TO A RESTRICTION THAT I REQUEST, THE RESTRICTION IS BINDING ON HIM.

I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT DR. SPOTTS OR HIS OFFICE HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT.

MY "PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION, COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER OR A HEALTH CARE CLEARINGHOUSE. THIS PROTECTED HEALTH INFORMATION RELATES TO MY PAST, PRESENT OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND IDENTIFIES ME, OR THERE IS A REASONABLE BASISTO BELIEVE THE INFORMATION MAY IDENTIFY ME.

I UNDERSTAND I HAVE A RIGHT TO REVIEW THE "NOTICE OF PRIVACY PRACTICES" FOR THIS OFFICE PRIOR TO SIGNING THIS DOCUMENT.

THE NOTICE OF PRIVACY PRACTICES HAS BEEN PROVIDED TO ME.

THE NOTICE OF PRIVACY PRACTICES DESCRIBES THE TYPES OF USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT WILL OCCUR IN MY TREATMENT, PAYMENT OF MY BILLS OR IN THE PERFORMANCE OF HEALTH CARE OPERATIONS BY DR. SPOTTS OR HIS OFFICE.

THE NOTICE OF PRIVACY PRACTICES FOR DR. SPOTTS' OFFICE IS PROVIDED AT 4900 SW GRIFFITH DR., STE 263, BEAVERTON, OR 97005.

THE NOTICE OF PRIVACY PRACTICES ALSO DESCRIBES MY RIGHTS AND THE DUTIES OF DR. SPOTTS OR HIS OFFICE WITH RESPECT TO MY PROTECTED HEALTH INFORMATION.

DR. SPOTTS RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES.

I MAY OBTAIN A REVISED NOTICE OF PRIVACY PRACTICES BY CALLING THE OFFICE AND REQUESTING A REVISED COPY BE SENT IN THE MAIL OR ASKING FOR ONE AT THE TIME OF MY NEXT APPOINTMENT.

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

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Client Registration Form

PERSONAL INFORMATION ***(if billing name and information are different, please indicate on back and mark here. ❑)***

Name: (Last)_____(First)_____(MI)_____
Address: Line 1: _____Apt #_____
Address: Line 2: _____City_____State _____ Zip_____
Hm Ph: (____) _____-_____ Ofc Ph: (____) _____-_____ Ext: _____
Cell Ph: (____) _____-_____ Pager: (____) _____-_____ Fax: (____) ____-_____
E-mail: _____@_____ WEB Site:_____
DOB: _____/_____/_____ SSN: _____-_____-_____ DLN _____State_____
Employer: _____ Occupation:_____
Yrs Ed: _____ School (if student)_____Church (if attending) _____
How were you referred to this office? _____

FAMILY & HOUSEHOLD INFORMATION

Marital Status: ❑ Never Married ❑ Currently Married ❑ Remarried ❑ Separated ❑ Divorced ❑ Widowed
Spouse: _____ Spouse Occupation:_____Number of Children: _____
Household Members (Other than Self) (use back if more space is needed)

NAME	*RELATIONSHIP*	*DOB*	*GRADE*	*OCCUPATION*

EMERGENCY CONTACT INFORMATION

Name of Contact: _____ Relationship: _____
Address: _____ City/State/Zip: _____
Hm Ph: (_____) _____-_____ Ofc Ph: (_____) _____-_____ Cell Ph: (_____) _____-_____

Insurance Information (*If other insurance or payers exist, add necessary information on back and mark here. ❑)*
Type: ❑ Medicare ❑ Medicaid ❑ Champus ❑ ChampVA ❑ Group Health Plan ❑ FECA Black Lung ❑ Other

Insured's Name: (Last)_____ (First)_____(MI)_____
Insured's DOB: _____/_____/_____ Ins ID#: _____ Relation to Insured: _____
Insurance Co: _____ Plan or Group Name: _____
Mail Claims to: _____ City/State/Zip: _____
Contact Phone: (_____) _____-_____ Employer: _____ Pol. or Grp. #: _____

• IT IS IMPORTANT TO KEEP THIS OFFICE AWARE OF ANY CHANGES IN THE INFORMATION RECORDED ABOVE.

AS CLIENT (OR LEGAL GUARDIAN OF A MINOR CLIENT), I AGREE TO PAY FOR ALL SERVICES RENDERED IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET FORTH IN THE "STATEMENT OF OFFICE POLICIES" FOR THIS OFFICE OF WHICH I HAVE RECEIVED A COPY. IF APPLICABLE, I HEREBY AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTOOD, AND NOW CONSENT TO ALL THE ABOVE TERMS AND CONDITIONS, AS WELL AS THOSE CONTAINED IN THE "STATEMENT OF OFFICE POLICIES."

_____ _____

Today's Date **Client Signature (parent or guardian's signature if client is minor)**

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Personal Information Sheet

(CONFIDENTIAL)

Name: (Last)_____ (First)_____ (M.I.)_____
Gender: ❑ Male ❑ Female
Marital Status: ❑ Never Married ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Marital History: Dates of Marriage(s)_____
Dates of Separations/Divorce(s)/Deaths _____

PRESENT CONCERNS (BRIEFLY DESCRIBE WHAT ISSUES OR CONCERNS LED YOU TO SEEK THERAPY AT THIS TIME)

PSYCHOLOGICAL SYMPTOMS CHECKLIST (MARK ITEMS BASED ON CURRENT OR RECENT FUNCTIONING.)

Mood Swings	❑	Memory Problems	❑	Too Much Sleep	❑	Lack of Energy	❑
Hopeless Feelings	❑	Too Little Sleep	❑	Excess Energy	❑	Alcohol Problems	❑
Anger or Irritability	❑	Racing Thoughts	❑	Drug Problems	❑	Physical Violence	❑
Slowed Thinking	❑	Wish to Die	❑	Panic Attacks	❑	Guilt Feelings	❑
Suicide Attempts	❑	Heightened Fears	❑	Unusual Experiences	❑	Confusion	❑
Unsure of Reality	❑	Other (List Below)	❑				

PHYSICAL SYMPTOMS CHECKLIST (MARK ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST 6 MONTHS.)

Headaches	❑	Alcohol Use	❑	Pregnancies	❑	Impaired Hearing	❑
Miscarriage	❑	Drug Use	❑	Abortion	❑	Impaired Vision	❑
Chest Pain	❑	Blackouts	❑	Miscarriage	❑	Weight Gain	❑
Seizures	❑	Memory Loss	❑	Stomach Discomfort	❑	Weight Loss	❑
Hypertension	❑	Numbness	❑	Poor Motor Control	❑	Compulsive Dieting	❑
Fainting	❑	Back Pain	❑	Tremors	❑	Vomiting	❑
Dizzy Spells	❑	Muscle Spasms	❑	Sexual Difficulties	❑	Other (List Below)	❑

Have you ever sought counseling or psychotherapy before? ❑ Yes ❑ No When?_____
Counselor/Therapist: _____Reason or Diagnosis: _____

Were you ever hospitalized for an emotional disorder? ❑ Yes ❑ No
Dates: _____ Hospital: _____Reason or Diagnosis:_____

MEDICAL HISTORY
Who is your PCP (Primary Care Physician)? _____

Name(s) of any other healthcare professionals currently providing you with treatment: _____

Describe any major diseases, disabilities, or injuries you have had.
_____
_____
_____

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PLEASE LIST ANY MEDICATIONS YOU ARE NOW TAKING, ALONG WITH THEIR CORRESPONDING DOSAGES.

MEDICATION	DOSAGE	FREQUENCY	TIME OF DAY

EMPLOYMENT HISTORY (START WITH CURRENT OR MOST RECENT JOB.)

ACADEMIC AND EDUCATIONAL HISTORY
(PLEASE **CIRCLE** HIGHEST LEVEL OF FORMAL EDUCATION & SELF-ESTIMATED LEVEL OF SUCCESS)

GS JH HS College (1y 2y 3y 4y) MA Doctoral Post Doctoral

Poor Limited Average Above Average Exceptional

LEGAL HISTORY (E.G. CRIMINAL VIOLATIONS, COURT APPEARANCES, CUSTODY HEARINGS, CIVIL SUITS, ETC.)

FAMILY HISTORY

Are Your Parents Alive? ❑ Yes ❑ No

(If so, are they in good health?) Mother ❑ Yes ❑ No Problems _____

Father ❑ Yes ❑ No Problems _____

HAS ANYONE WITHIN YOUR IMMEDIATE OR EXTENDED FAMILY EXPERIENCED ANY OF THE FOLLOWING?

	RELATION TO YOU STEPCHILDREN
Depression	❑ _____
Anxiety	❑ _____
Mood Swings	❑ _____
Schizophrenia	❑ _____
Suicide or Attempts	❑ _____
Drug/Alcohol Abuse	❑ _____
Emotional Illness	❑ _____
Imprisonment	❑ _____

PLEASE LIST CHILDREN AND/OR

NAME	*AGE*

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NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact **Dr. Spotts** directly at **503.526.9304 or at 4900 SW Griffith Dr., Ste 263, Beaverton, OR 97005.**

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by any employees, staff or other office personnel. The practices described in this notice will also be followed by the health care providers who provide "call coverage" for Dr. Spotts should you consult with them by telephone (when Dr. Spotts is not available).

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with psychological treatment or services. We may disclose health information about you to other doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a psychological condition and may need to know if you have other health problems that could complicate or bear on your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for psychological treatment or assessment at the office.

Treatment Alternatives

We may contact you about or recommend possible treatment options or alternatives that may be of interest to you.

HealthRelated Products and Services

We may contact you about healthrelated products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or healthrelated products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for workrelated injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, nonaccidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

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Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to Dr. Spotts in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to Dr. Spotts. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *a Request For Restricting Uses and Disclosures and Confidential Communications Form* Information to Dr. Spotts**.**

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit *the Requests For Restricting Uses and Disclosures and Confidential Communications* to Dr. Spotts. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Dr. Spotts or his office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. Spotts at 503.526.9304**.** You will not be penalized for filing a complaint.