New Patient Registration Information

PATIENT INFORMATION					
Last Name	First Name	Middle Name			
Social Security Number	Gender	Date of Birth	Name you preferred to be called/Alias		
Street Address	City	State	Zip		
Home Phone	Work Phone	Cell Phone	Email		
Marital Status	Previous/Maiden Name	Written Language	Spoken Language		
Interpreter Needed?	VA Status ☐ Yes ☐ No	Race/Ethnicity (optional)			
Primary Care Provider (Name and Phone)	Employer Name				
Emergency Contact	Relation	Home Phone	Work Phone	Cell Phone	
Legal Next of Kin *(if different)*	Relation	Home Phone	Work Phone	Cell Phone	

RESPONSIBLE PARTY INFORMATION (if different from patient)				
Last Name	First Name	MI	Alias or Maiden Name	
Social Security Number	Gender	Date of Birth	Relationship to the Patient	
Street Address (if different from above)	City	State	Zip	
Home Phone	Work Phone	Cell Phone		
Employer Name	Occupation	Status		

PRIMARY INSURANCE				
Insurance Company Name	Group Number	Subscriber ID Number	Copay	
Subscriber's Name	Social Security Number	Date of Birth	Relationship to Patient	
Subscriber's Employer Name	Subscriber's Home Phone	Subscriber's Work Phone		

SECONDARY INSURANCE				
Insurance Company Name	Group Number	Subscriber ID Number	Copay	
Subscriber's Name	Social Security Number	Date of Birth	Relationship to Patient	
Subscriber's Employer Name	Subscriber's Home Phone	Subscriber's Work Phone		

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to The Charis Clinic PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize Charis Clinic PLLC to release the necessary information for use by insurance company(ies) for processing claims for treatment and/or for requesting the authorization of additional sessions, including the release of personal health information, diagnosis, and clinical information.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Printed Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Note for clients between the ages of 13 and 26: If a parent(s) is responsible for the billing aspects of treatment, please make sure the parent(s) provide the above information and signatures.

Is This Visit Related to a Work Injury or Motor Vehicle Accident? ***If "yes", please complete the below.***

☐ **Work Related Injury**

Worker's Comp (Includes Labor & Industries)

Employer:		Date of Injury:
Body Part Injured and Description:		Claim Number:
Adjuster/Claims Manager Name:		Phone Number:
Insurance Name:	Address:	
City:	State/Zip:	L & I Claim Completed? Yes No

☐ **Motor Vehicle Accident (PIP) Insurance**

Personal Injury Protection Insurance (Third Party/Motor Vehicle)

Date of Injury:	Body Part Injured and Description:
Claim Number:	Adjuster/Claims Manager Name:
Adjuster Phone Number:	Insurance Name:
Insurance Address:	
City:	State/Zip:

Charis Clinic ADOLESCENT/ADULT Medical History Information

(13 and older)

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Sex: _____Male _____Female Hm phone_____ Cell phone _____ Work phone _____Email _____

Primary Care Provider_____ Current Counselor/Therapist _____

Pharmacy Name _____ Pharmacy #(____)_____

Problems you are seeking care for _____

REVIEW OF SYSTEMS (Please answer if you are having any of these symptoms CURRENTLY):

General: ☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Weakness ☐ Awakening feeling unrefreshed
Skin: ☐ Rashes ☐ Lumps ☐ Itching ☐ Dryness ☐ Color changes ☐ Hair or nail changes
Head: ☐ Headache ☐ Head injury
Ears: ☐ Decreased hearing ☐ Ringing in ears ☐ Earache ☐ Drainage
Eyes: ☐ Visual change _____ ☐ Glasses or contacts ☐ Eye pain ☐ Redness ☐ Blurry or double vision ☐ Flashing lights
Nose: ☐ Stuffiness ☐ Discharge ☐ Itching ☐ Hay fever ☐ Nosebleeds ☐ Sinus pain
Throat/Mouth: ☐ Tooth problems ☐ Sore tongue ☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush
Neck: ☐ Lumps ☐ Swollen glands ☐ Pain ☐ Stiffness
Breasts: ☐ Lumps ☐ Discharge ☐ Pain
Respiratory: ☐ Cough (dry or productive)? ☐ Sputum color _____ ☐ Coughing up blood ☐ Wheezing ☐ Shortness of breath ☐ Alcoholism
Cardiovascular: ☐ Chest pain or discomfort ☐ Chest tightness ☐ Palpitations ☐ Shortness of breath with activity ☐ Difficulty breathing lying down ☐ Swelling (edema) ☐ Sudden awakening from sleep with shortness of breath
Gastrointestinal: ☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Nausea ☐ Change in bowel habits ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea ☐ Vomiting
Urinary: ☐ Frequency ☐ Urgency ☐ Burning or pain ☐ Blood in urine ☐ Incontinence ☐ Change in urinary flow
Genital/Reproductive: **Male--**☐ Pain with sex ☐ Hernia ☐ Penile discharge ☐ Genital sores ☐ Masses or pain ☐ Difficulty sustaining an erection
Female--☐ Pain with sex ☐ Vaginal dryness ☐ Hot flashes ☐ Vaginal discharge ☐ Vaginal itching or rash ☐ Sores
Extremities: ☐ Calf pain with walking ☐ Leg cramping
Musculoskeletal: ☐ Muscle pain ☐ Joint pain ☐ Stiffness ☐ Back pain ☐ Redness of joints ☐ Swelling of joints ☐ Recent trauma/injury
Neurologic: ☐ Dizziness ☐ Fainting ☐ Seizures ☐ Weakness (localized/in one area only) ☐ Numbness ☐ Tingling
Hematologic: ☐ Easy bruising
Endocrine: ☐ Heat or cold intolerance ☐ Sweating ☐ Frequent urination ☐ Thirst ☐ Eating much more than usual
Psychiatric: ☐ Nervousness/anxiety ☐ Depression ☐ Memory loss ☐ Stress ☐ Poor motivation ☐ Difficulty concentrating

Suicide Risk Assessment

Have you wished you were dead or wished you could go to sleep and not wake up? Yes □ No □
Have you actually had any thoughts of killing yourself? If yes, describe: _____Yes □ No □
Have you been thinking about how you might do this? If yes, describe: _____Yes □ No □
On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill yourself currently? _____
Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide? _____
Have you ever made a suicide attempt in the past? Yes □ No □ If yes, when was this? _____
Have you done anything to harm yourself, including cutting? Yes □ No □ If yes, describe: _____
Have you ever had a family member commit suicide? Yes □ No □ If yes, when and who? _____
Have you done anything dangerous where you could have died? Yes □ No □ What did you do? _____
Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything? If yes, describe: _____Yes □ No □ Total # of interrupted attempts _____
Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)? If yes, describe: Yes □ No □ Total # of preparatory acts _____ Most Recent date of attempt _____

PAST MEDICAL HISTORY

Are you allergic to any medications? Yes □ No □: which ones (list REACTION after each)?_____
_____

Do you have any history of:

☐ Alcoholism	☐ Anxiety	☐ Arthritis
☐ Allergies (to _____)	☐ Anorexia	☐ Asthma
☐ Anemia	☐ Appendicitis	☐ Bleeding Disorder

☐ Blood Clot
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer (type____)
☐ Cataract
☐ Chronic Pain
☐ Diabetes
☐ Depression
☐ Drug Use (type _____)
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart Failure
☐ Hepatitis (type ____)
☐ Hernia
☐ High Cholesterol
☐ HIV positive
☐ Kidney Disease
☐ Kidney Infection
☐ Kidney Stone
☐ Liver Disease
☐ Migraine headaches
☐ Metabolic Disorder
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Osteoporosis
☐Peptic Ulcer
☐ Pneumonia
☐Prostate problem
☐ Reflux (GERD)
☐Rheumatic Fever
☐Scarlet Fever
☐Sexually transmitted infection (type ____)
☐Stroke
☐Suicide attempt
☐Thyroid problem
☐Tonsillitis
☐Tuberculosis
☐Tropical disease (type_____)
☐Urinary tract infection
☐Vaginal infection
☐ Other(_____

Have you had any surgeries? Please list type and approximate date:
_____
Have you ever been hospitalized? Yes □ No □. If yes, for what reason? _____
Have you ever had a blood transfusion? Yes □ No □ If yes, approximate date _____
Have you served in the armed forces? Yes □ No □ If yes, indicate type & years of service _____

List ALL medications you currently take. Include all prescription, over-the-counter and herbal medications and the dose of each.
_____ _____
_____ _____

FAMILY MEDICAL HISTORY

	Father	Mother	Child	Sibling	Grandparent	Other
Alcoholism	☐	☐	☐	☐	☐	☐
Alzheimers/Dementia	☐	☐	☐	☐	☐	☐
Asthma or Allergies	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer: type _____	☐	☐	☐	☐	☐	☐
Depression, Anxiety	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐

Please list any other conditions in your family: _____

SOCIAL HISTORY

Race (check all that apply): □ African-American □ Caucasian □ Native American □ Asian □ Hispanic/Latino □ Arab/Middle Eastern □ Pacific Islander □ Other _____**Ethnic/country background**:_____
Preferred Language: _____ Other Languages spoken: _____

Substances

Have you ever used nicotine products? Yes □ No □ **If yes**, what kind? Cigarettes □ Pipe □ Vaping/electronic □ Chewing tobacco □
If yes, for how many years? ___ How much do you smoke now? _____**If you no longer smoke**, when did you stop? _____
Do you drink alcohol? _____ Kind of alcohol? _____ Number of alcoholic drinks/servings you consume per week? ___ Most at one time?____
Have you ever had a problem with alcohol or felt you should cut down? _____
Have you ever used substances? Yes □ No □. If yes, indicate type: Cocaine □ Heroin □ Cannabis □ LSD □ Methamphetamines □ LSD/Mushrooms/Hallucinogens □ Opioids/pain pills □ Benzodiazepines/tranquilizers □ Ecstasy □ Stimulants □ Other _____
If yes, How long and when was the last time you used?_____
Have you ever overused prescription medications? ___No ___If yes, type _____
Caffeine Use: # ___ soda ___ tea ___ coffee per day

Family Background and Childhood History
Were you adopted? Yes □ No □
List your siblings and their ages_____Father's occupation_____ Mother's occupation _____
Did your parents divorce? Yes □ No □ How old were you when they divorced? _____ Who did you live with afterwards? _____
Has anyone in your immediate family died? Yes □ No □ If so, who and when? _____
Who do you live with? _____

Trauma
Do you have a history of being abused emotionally, verbally, sexually, physically or by neglect? Yes □ No □
Describe_____

Educational History
Did you attend college or trade school? Yes □ No □ Where? _____ Major _____
Highest educational level or degree attained? _____

Occupational history
Are you currently: Working □ Not working by choice or stay at home parent □ Retired □ Unemployed □ Disabled
Other □_____How long in your present position? _____Do you like your work? Yes □ No □
What is your occupation? _____ Where do you work? _____
Any occupational concerns: (stress, hazardous substances, air pollution, heavy lifting)? _____

Relationship History, Current Family, Sexual Orientation
Are you: Single □ Married □ Partnered □ Separated □ Divorced □ Polyamorous □
Are you sexually active? Yes □ No □ Do you feel safe in your current relationship? Yes □ No □
How would you identify your sexual orientation? Straight/heterosexual □ Lesbian/gay/homosexual □ Bisexual □ Unsure/questioning □ Asexual □
Other □ _____Gender identity: Male □ Female □ Transgender □ Gender fluid/Nonbinary □
Do you have children? Yes □ No □ If yes, list ages and gender _____

Exercise: Indicate current type, duration & frequency _____

Spirituality
Do you belong to a particular religion or spiritual group? Yes □ No □
What is your religious/faith background?_____ What is your level of involvement?_____ Where do you attend? _____
Do you find your involvement helpful during this illness or does involvement make things more difficult or stressful for you? Helpful □ Stressful □
Do you have a Health Care Directive? Yes □ No □ If no, would you like to have one? _____

Date: _____ Patient Signature (or legal guardian) _____

Child and Adolescent History Form

CONFIDENTIALITY

All of the information that you provide in this form is strictly confidential. It cannot be released to anyone without your specific written permission.

REQUEST FOR OTHER INFORMATION

In addition to completing this lengthy but important form, please provide us with copies of all previous evaluations, reports, psychological testing, and medical records you have available. Please submit with your paperwork or request to have them sent to us.

PERSON COMPLETING FORM _____ **TODAY'S DATE**_____

Relationship to child _____

CHILD INFORMATION

Full Name _____ Date of Birth _____ Age_____ Sex____

REFERRAL SOURCE

Name _____ (for first two choices below)

Type: Please describe how your referral to us came about.

- ⑨ Primary Care Physician _____
- ⑨ Other Mental Health Provider _____
- ⑨ Self _____
- ⑨ Friend _____
- ⑨ Other _____

HOME SITUATION

Child primarily lives with: **Please list names, ages, relationship of all who live with child**

	Name	Age	Relationship
⑨ Biological Mother			
⑨ Biological Father			
⑨ Adoptive Mother			
⑨ Adoptive Father			
⑨ Stepmother			
⑨ Stepfather			
⑨ Foster Parents			
⑨ Other Guardian Parents			

Custody:

Who is the child's legal guardian(s)? _____

Who has custody? _____

Please describe terms of visitation.

If foster care, please describe circumstances. _____

Caseworkers name and phone number: _____

If adopted, does the child know about the adoption? ⑨ Yes ⑨ No

Housing:

Type of Housing:

⑨ Single Family House

⑨ Apartment/Townhome

Number of bedrooms _____

Does child share a room? ⑨ Yes ⑨ No

With whom? _____

⑨ Mobile Home Is this ⑨ parent's home?

⑨ Motel/Shelter ⑨ staying with friend or relative?

Other important relationships:

Please list other people important in the child's life, people who have regular contact or influence. This list may include grandparents, siblings outside the home, sitters/daycare providers, etc.

Name	**Relationship**

YOUR MAIN CONCERNS

Description:

Please describe as specifically as possible the child's major problems that have led you to seek consultation with us at this time.

Problem List:

Please list the problems identified above, and others you think of, from most severe to least severe.

Problem	**Date first noticed (approx)**
1.	
2.	

Causes and Triggers:

Referring to the problem number above, please describe what you believe to be the causes of these problems and identify any situations that trigger or worsen the problems. (For example: A learning disorder in spelling may cause frustration and anger triggered by spelling homework).

1.

2.

Related Stresses and Changes:

Have there been any changes or stressful situations lately (new baby sibling, moves, change in schools, change in visitation pattern, any traumatic events or losses, divorce of parents, etc.)?

Impact of Problems:

How have these problems impacted your child and family?

School behavior, grades, and peer relationships:

Home behavior and family relationships:

Neighborhood/community relationships, legal problems:

If there are any legal issues please specify charges, status, consequences, future court processes, dates if known.

GOALS FOR EVALUATION AND TREATMENT

Please list specific goals you have for your child's evaluation and treatment. What do you hope the evaluation and treatment will accomplish? Please prioritize these goals.

1.

2.

3.

PAST MENTAL HEALTH HISTORY

Current Treatment:
Please identify current treatment providers (therapists, psychologists, primary care, school counselor, pastoral counselor etc.), type of treatment (therapy, family therapy, medication, etc.), and when treatment started.

	Clinician Providing Treatment	Type of Treatment and effectiveness	Date Began
1.			
2.			
3.			

Past Treatment:
Please identify past treatment providers similar to those above:

	Clinician Providing Treatment	Type of Treatment and effectiveness	Approximate Dates
1.			
2.			
3.			

Past Psychiatric Hospitalizations:
Please list past hospitalizations, residential placements, or other treatment programs where the child stayed outside of the home. If more than once to same facility, just list once with approximate dates.

	Name of Facility	City/St if not local	Date
1.			
2.			
3.			

MEDICATION HISTORY
Please identify medication allergies (rashes, breathing problems, etc.) or adverse reactions (severe side effects) and describe. Include all medicines, not just psychiatric.

Current Medications:
Please list all current medications the child takes. Please list psychiatric medications first followed by routine medical medicines, then list frequent (monthly or more) "PRN" or "as needed" medicines (e.g. Tylenol). Please identify approximate start date for daily medicines. Please also identify herbal, "natural" medicines, or vitamins.

Medicine	Dose	Date Started	Benefits	Suspected Side Effects

Past Medications:
Please list past psychiatric medicines used. Start with the most recent before the above current medicines. List approximate dates used. List starting and maximum doses if possible. If you need more space, please use the last page or provide a separate sheet. For example:
(Ritalin 5 mg TID to 15 mg TID 1/00 – 8/02 helped hyperactivity poor sleep and appetite)

Medicine	Doses	Dates Used	Benefits	Suspected Side Effects

PAST MEDICAL HISTORY

Primary Care Physician:

Name _____Facility_____ Approximate date last seen _____
Conditions being treated_____

Other Physicians/Specialists:
Name _____Facility _____ Approximate date last seen _____
Conditions being treated_____

Medical Conditions:
Please identify any significant problems with conception, pregnancy, or delivery. (e.g. use of fertility agent, "high risk" status, exposure to toxic substances, premature, delayed, or emergency delivery, NICU).

Please identify any developmental disabilities, birth defects, vision, speech, or hearing problems.

Please identify any problems of early childhood (e.g. feeding problems, "failure to thrive", apnea, very high fever, delay in developmental milestones = crawling, walking, toilet training, dressing, coordination, etc.)

Please identify any chronic medical conditions requiring ongoing care. (e.g. diabetes, asthma, hemophilia, etc.)

Please identify any unusual diseases or infections (meningitis, encephalitis, tuberculosis, etc.)

Please identify any neurological problems (e.g. seizures) or significant head injury (e.g. loss of consciousness).

Please identify any intermittent but significant medical problems (e.g. severe menstrual problems, migraines).

FAMILY HISTORY

Please identify if any of the child's biological relatives (parents, grandparents, aunts, uncles, cousins, or siblings) have had the following conditions. Please identify the relationship using "maternal" for mother's side and "paternal" for father's side as it pertains to the child

Problem (Circle specific condition or add name of related condition along with person affected)	**Relative Affected**
Medical:	
Cardiac (Heart disease, sudden cardiac death, high blood pressure, stroke, mitral valve prolapse/other heart condition)	
Diabetes	
Thyroid disease	
Epilepsy (seizures, convulsions)	
Tourette's Disorder, motor or vocal tics	
Developmental or cognitive:	
Intellectual delay	
Developmental delay	
Autism spectrum/aspergers	
Learning disorders (dyslexia, ADHD)	
ADHD, attention, hyperactive, impulse control problems	
Educational:	
Severe academic problems	
Severe school behavior problems	
Did not finish high school	
Environmental (including non-blood relative housemates):	
Suffered physical abuse, sexual abuse, or	
Exposure to toxins (e.g. lead, arsenic, asbestos)	
Behavioral:	
Aggressive criminal behavior, assaults	
Legal problems (repeat offenses, arrests)	
Violent behavior	
Stealing, lying, cruelty to people or animals	
Destruction of property, fire setting	
Psychiatric:	
Anxiety, OCD, phobias "nerve problems"	
Depression	
Manic depression/bipolar disorder	
Schizophrenia, schizoaffective, psychosis	
Suicide attempts or completions (specify which)	
Admission to psychiatric hospital	
Borderline personality disroder	
Substance Abuse:	
Alcohol use disorder	
DUI, especially repeat offenders	
Substance use disorder, "street" or prescription	

SOCIAL HISTORY

Parent's Relationship:

Describe parent's marriage relationship.

If divorced, describe relationship between divorced parents. Include issues related to custody, child support, and visitation.

Please describe types of discipline used in the home. Include privileges, responsibilities, and consequences (punishments) for the child.

Moves:

Please list all family moves since the child's birth. Identify the year of the move.

Child's Issues:

Peers:

Does your child have many friends? ⦾ Yes ⦾ No

Do you approve of your child's friends? ⦾ Yes ⦾ No

What concerns you or satisfies you about the friends?

Would you describe your child as a follower or a leader?

Substance Use:

What do you know or suspect about your child's use of nicotine, marijuana, alcohol, cocaine, or other substances?

Difficult Experiences:

History of trauma during your child/adolescent's lifetime (e.g., abuse, neglect, sexual abuse, witnessing domestic or community violence):

Current or Most Recent School: ⦾ Public ⦾ Private ⦾ Home School

Has your child every repeated a year? Indicate year and why.

Has your child received special education designation or services? Specify type and grade level.
This includes speech, tutoring, reading help as well as learning disorder, emotional disorder, behavior disorder, Also include advanced placement, high cap programs.

Does your child otherwise have an IEP separate from above? Is there a "504 Accommodation Plan"?

Has your child been tested for any of the above? If so, what year? Try to provide a copy of the evaluation.

Timeline:

For each year, include grades, behavior, and overall function

Grade	Name of School	Average Grade	Behavior	Overall Function

ANYTHING ELSE?

Use this space to answer questions you may not have had room for. Please refer to the page and section. Use this space to say anything else you would like to share.

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months*.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	**PN**
2. I get headaches when I am at school.	O	O	O	**SH**
3. I don't like to be with people I don't know well.	O	O	O	**SC**
4. I get scared if I sleep away from home.	O	O	O	**SP**
5. I worry about other people liking me.	O	O	O	**GD**
6. When I get frightened, I feel like passing out.	O	O	O	**PN**
7. I am nervous.	O	O	O	**GD**
8. I follow my mother or father wherever they go.	O	O	O	**SP**
9. People tell me that I look nervous.	O	O	O	**PN**
10. I feel nervous with people I don't know well.	O	O	O	**SC**
11. I get stomachaches at school.	O	O	O	**SH**
12. When I get frightened, I feel like I am going crazy.	O	O	O	**PN**
13. I worry about sleeping alone.	O	O	O	**SP**
14. I worry about being as good as other kids.	O	O	O	**GD**
15. When I get frightened, I feel like things are not real.	O	O	O	**PN**
16. I have nightmares about something bad happening to my parents.	O	O	O	**SP**
17. I worry about going to school.	O	O	O	**SH**
18. When I get frightened, my heart beats fast.	O	O	O	**PN**
19. I get shaky.	O	O	O	**PN**
20. I have nightmares about something bad happening to me.	O	O	O	**SP**

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	O	O	O	**GD**
22. When I get frightened, I sweat a lot.	O	O	O	**PN**
23. I am a worrier.	O	O	O	**GD**
24. I get really frightened for no reason at all.	O	O	O	**PN**
25. I am afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for me to talk with people I don't know well.	O	O	O	**SC**
27. When I get frightened, I feel like I am choking.	O	O	O	**PN**
28. People tell me that I worry too much.	O	O	O	**GD**
29. I don't like to be away from my family.	O	O	O	**SP**
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. I worry that something bad might happen to my parents.	O	O	O	**SP**
32. I feel shy with people I don't know well.	O	O	O	**SC**
33. I worry about what is going to happen in the future.	O	O	O	**GD**
34. When I get frightened, I feel like throwing up.	O	O	O	**PN**
35. I worry about how well I do things.	O	O	O	**GD**
36. I am scared to go to school.	O	O	O	**SH**
37. I worry about things that have already happened.	O	O	O	**GD**
38. When I get frightened, I feel dizzy.	O	O	O	**PN**
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	**SC**
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	**SC**
41. I am shy.	O	O	O	**SC**

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012

INFORMED CONSENT FOR TELEHEALTH

This Informed Consent for Telehealth services contains important information focusing on receiving services using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telehealth

Telehealth refers to providing clinical services (including physical health evaluation, psychiatric evaluation, psychotherapy, etc.) remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the client and clinician can engage in services without being in the same physical location. This can be helpful for ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person services and telehealth services, as well as some risks. For example:

- Location. Because I am licensed only in the state of Washington, you must be located within the state of Washington at the time of the visitto receive services.

- Risks to confidentiality. Because telehealth sessions take place outside of the provider's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your computer or other device. You should participate in telehealth services only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telehealth, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telehealth work. Typically, this consists of you or I calling 911 or seeking transport to the nearest emergency department.

- Efficacy. Most research shows that telehealth is about as effective as in-person services. However, some providers believe that something is lost by not being in the same room.

For example, there is debate about a therapist's ability to fully understand non-verbal communication (facial expressions, hand gestures, body postures) when working remotely, which could lead to inadequate diagnosis and treatment plan.

Electronic Communications

We will decide together which kind of telehealth service to use. You may need certain computer or cell phone systems to use telehealth services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telehealth. As of the date of the last revision, our systems work best on the Chrome browser.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are part of our telehealth. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in telehealth. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telehealth

From time to time, we may schedule in-person sessions to check-in with one another face-to-face. I will let you know if I decide that telehealth is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

If a telehealth session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telehealth platform on which we agreed to conduct therapy. If we are not able to reconnect via the telehealth platform, I will call you at the phone number that is on file for you.

If there is a technological failure and we are unable to resume the connection by any manner, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telehealth as apply for in-person services. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic telehealth services, you may be solely responsible for the entire fee of the session. **Please contact your insurance company prior to our engaging in telehealth sessions to determine whether these sessions will be covered**.

Records
Our telehealth sessions will not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain professional records of in-person sessions in accordance with my policies.

Informed Consent
This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

Confirmation of Agreement

Clients 13 years and older:

Client Printed Name_____Signature _____ Date_____

Parent or Guardian, if client is under 13 years of age:

Printed Name _____Signature_____ Date _____

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.

The Charis Clinic PLLC is a professional limited liability company.

The privacy of your health information is important to us. We will maintain the privacy of your health information and we will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) requires that we take additional steps to keep you informed about how we may use information that is gathered in order to provide health care services to you. As part of this process, we are required to provide you with the attached Notice of Privacy Practices and to request that you sign the written acknowledgment that you received a copy of the Notice. The Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights.

Please take a moment to review our Notice of Privacy Practices. We also request that you sign and return the attached Acknowledgment of Receipt of Notice of Privacy Practices documenting that you received a copy of our Notice.

If you have questions about this Notice, please contact our Privacy Officer at:

The Charis Clinic
7631 212th St SW Ste 101A.
Edmonds, WA 98026
phone 206.714.4476
fax 425.732.4476

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFROMATION. Please review it carefully.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

Treatment: We may use and disclose protected health information (PHI) to provide, coordinate and manage your health care, including consulting between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose PHI to obtain reimbursement for the treatment and services provided to you, including the determination of eligibility of coverage and other utilization review activities. We may disclose limited PHI to consumer reporting agencies relating to collection of payment owed to us.

Healthcare Operations: We may use and disclose PHI to support functions of our practice related to treatment and payment, such as quality assurance actives, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning and developments, management and administrative actives.

Business Associates: There may be some services provided in our organization through contacts with business Associates. This would include our billing management system, electronic claims clearing house or physician services in the emergency department and radiology. When these services are contacted, we may disclose some or all of your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release PHI about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may release PHI to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease of condition.

Health Oversight Activities: We may disclose PHI to federal or state agencies that oversee our activities.

Required or Permitted by Law: We may disclose PHI as required or permitted by law or in response to a valid judge-ordered subpoena. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health and safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to

military or national security agencies, coroners, medical examiners, and correctional institutions as otherwise authorized by law.

Military and Veterans: If you are a member of the armed forces, we may release PHI about you as required by military command authorities.

Lawsuits and Disputes: We may disclose PHI about you in response to a court or administrative order. We may also disclose medical information about you to in response to a subpoena, discovery request or other lawful purposes. We may disclose medical information about you in order to protect ourselves from complaints or legal action filed against us.

Inmates: If you are an inmate of a correctional institute or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official.

Abuse or Neglect: We may disclose PHI to notify the appropriate government authority if we have reasonable suspicion that a patient or other reported person related to patient has been the victim of abuse, neglect or domestic violence. We will only make this disclose if you agree or when required or authorized by law.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release PHI about patients of funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for such purposes as controlling disease, injury or disability.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product or product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Vaccine Adverse Event Reporting System (VAERS): We may disclose to the VAERS information relative to adverse events from vaccines.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

B. Uses and Disclosures that May be Made Without Your Authorization, But for Which You have an Opportunity to Object

Appointment Reminders: Unless you object in writing, we may use and disclose PHI to contact you to provide appointment reminders such as voicemail messages, emails, texts, postcards, or letters.

Treatment Alternatives/Other Services: We may use and disclose PHI to tell you about or recommend possible treatment alternatives or other health care related benefits and services that may be of interest to you.

Family and Other Individuals Involved in Your Care or Payment for Your Care: We may use or disclose health information to notify, or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. We may ask you to identify others to whom we may disclose your health information. If you are present, then prior to such use or disclosure of your health information, we will provide you with an opportunity to object to such disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or other similar forms of health information.

Research: We may use and disclose PHI about you for research purpose under certain limited circumstances. We will obtain a written authorization to use and disclose PHI about you for research purpose except in situations where a research project meets specific, detailed criteria **established by the HIPPA Privacy Rule to ensure the privacy of your PHI.**

C. Uses and Disclosures Requiring Your Written Authorization

1. **Marketing Communications; Sale of PHI.** We must obtain your written authorization prior to using or disclosing PHI for marketing or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA

2. **Other Uses and Disclosures**. Uses and disclosures other than those described in Sections A and B above will only be made with your written authorization. For example, you will need to sign an authorization form before we can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

3. **Uses and Disclosures of Higher Confidential Information**. In addition, federal and state law requires special privacy protections for certain highly confidential information about you, including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment, and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about sexually transmitted

infections. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

1. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested.
2. Right to Alternative Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
3. Right to Request Restrictions. You have the right to request a restriction on PHI we use or disclose for treatment, payment, or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. We are not required to agree to any such restriction you may request, except if your request is to restrict disclosing PHI to a health plan for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf.
4. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by The Charis Clinic PLLC within the last six year. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.
5. Right to Request Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
6. Right to Obtain Notice. You have the right to obtain a paper copy of this notice by submitting a request to our Privacy Office at any time.
7. Right to Receive Notification of a Breach. We are required to notify you if we discover a breach of your unsecured PHI, according to requirements under federal law.
8. Questions and Complaints

OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

We are required by law and under the HIPPA Privacy Rule to maintain the privacy of your health information. In addition, we are required to provide you with our legal duties and privacy practices with respect to information we collect and maintain about you. We must comply with the terms of this notice. We reserve the right to make changes to this notice and to make such changes effective

for all PHI we may already have about you. If and when this notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised notice upon request to our Privacy Official.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Official at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a written complaint with the Privacy Office at The Charis Clinic PLLC, or the Secretary of the Department of Health and Human Services. We will not retaliate or take action against you for filing a complaint with the Privacy Official at The Charis Clinic PLLC.

The contact information is included below:

US Department of Health and Human Services
Office of the Secretary
200 Independence Ave. SW
Washington DC 20201
phone 202.619.0257
toll free 1.877.696.6775
http://www.hs.gov/contacts

The Charis Clinic
7631 212th St SW Ste 101A
Edmonds, WA 98026
phone 206.714.4476
fax 425.732.4476

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
The Charis Clinic PLLC

PURPOSE: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document a good faith effort to obtain the acknowledgement.

You may refuse to sign this acknowledgement.

I, _____, have received a copy of Charis Clinic's Notice of Privacy Practices. printed complete name

_____ _____

Patient/Parent (circle which) Signature Date

--For Office Use Only--

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other _____

DISCLOSURE STATEMENT

Background and Training

I am a nurse practitioner, licensed in Washington state. I have been licensed in Washington state since 1994 as a family nurse practitioner. Prior to that, I was a hospital and outpatient clinic pediatric nurse. As a family nurse practitioner, my practice focused on the concerns of women, children, and those with chronic disease and mental health concerns. Between 2005 and 2008 I was an assistant professor of family nurse practitioner students at Seattle University and a temporary professor of Seattle Pacific University. In 2005, I obtained my doctorate as a nurse practitioner, and in 2020 I completed a certificate as a psychiatric mental health nurse practitioner. I am board certified as both a FNP and a PMHNP (psychiatric mental health nurse practitioner).

Professional Associations

I am a member of the American Academy of Nurse Practitioners, ARNPs United, and the Association of Advanced Practice Psychiatric Nurses. I attend ongoing professional training, workshops and seminars to further my skills in working with children, adolescents, and adults. I am also involved routinely in a consultation group to enhance my work with my clients. If I consult with a professional who is not involved in your treatment, I will protect your identity. These professionals are legally bound to keep all information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

Typically, sessions occur every week to every other week initially, then monthly, and finally, once your treatment plan is stabilized, follow ups may occur as infrequently as every three months. You are free to end your treatment with me at any time, for any reason. If you do not have an appointment scheduled, and I do not hear from you for 90 days to make an appointment, and you do not respond to a follow up request phone call, I will interpret this to mean you are ending your treatment with me.

Social Networking Policies

Charis Clinic has a webpage that coordinates with a Facebook page and Twitter account. If you choose to interact on Facebook, or Twitter, or another social networking site, and your name is easily identifiable, please be aware that the information you post there will be public, and could compromise your confidentiality. It may also create the possibility that these exchanges will become part of your legal medical record nad need to be documented and archived in your chart.

I do not accept friend or contact requests from current or former clients on Facebook, LinkedIn, or any other social media. If there are things from your online life (including emails) that you wish to share with me, please bring them into our sessions where we can view and explore them together.

Please do not use SMS (mobile phone text messaging) or messaging on social networking sites to contact me. These sites are not secure, and I may not read these messages in a timely fashion. Do not use wall posting or other means of engaging me in a public online medium if

you have already established a therapeutic relationship. I do not interact with clients in this manner.

Please do not email me personal health information, as email is not encrypted, and therefore, not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet service providers. If you contact me via email, I will assume that you approve of my replying to you and accept these privacy and other risks.

Regular Hours and Availability
I am available during published office hours (currently Monday 9-4, Tuesday 9-12, Wednesday 9-4, Thursday 9-12, and Friday 9-4; these will change in 2022). Our office is open on Mondays, Wednesdays, and Fridays except for holidays. If you need to reach me between those times, you can call 206-714-4476 and leave a voicemail. I will return the call as soon as possible according to urgency. If in CRISIS, please call my number, but also call the Suicide Prevention Lifeline at 1-800-273-TALK (8255). I will make every effort to return your call within 48 hours.

FINANCIAL, PAYMENT AND OTHER POLICIES
Thank you for choosing The Charis Clinic PLLC as your psychiatric care provider. We are committed to providing you with high quality health care. Please understand that payment for services is necessary for us to continue to provide care to all. The following are our standard Financial, Payment, and Other Policies. Please read them, ask us any questions you may have, and sign in the space provided. We will provide a copy to you upon request.

1. Insurance. We participate in most insurance plans, with the exception of Aetna, Multicare, United Healthcare state plans, and Medicare. If you are not insured by a plan we do business with, you must pay in full at each visit. Please note that **we cannot bill your insurance company unless you give us complete, accurate, and current insurance information**. If you are insured by a plan we do business with, but you don't have an up-to-date insurance card, you must pay in full for each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. You must pay all co-payments **at the time of service**. This arrangement is part of your contract with your insurance company. **Additionally, if you have a high-deductible plan (greater than $500 per individual or family), you will be required to pay an estimate of the portion you are responsible for at the time of service**.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. You must pay for these services in full.

4. Proof of insurance. All patients must complete our patient information form before seeing their health care provider. We also require identification with your driver's license and a current valid insurance card. If you fail to provide us with the current insurance information, we may not able to see you, and if we discover the information is not current or correct, you will be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that

the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Please note that we bill separately for preventative and problem issues. If you bring up a problem, or if in the course of discussion it is apparent that you have a problem that needs evaluated, you will be billed separately for these issues. Please do not ask us to re-bill the insurance company differently, as we are careful to avoid fraud.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If we do not participate in the new plan, you will need to pay cash fees up front. If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you.

7. Payments and Nonpayment. Payments will occur automatically via the credit card agreement below. If for some reason a check is provided, note that a $25 fee will be assessed for returned checks, plus any additional fees the bank has charged us. Payment for the fee and unpaid balance must be made by cash or credit card before additional sessions are scheduled. If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in FULL. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members will be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative care. If legal action is necessary to collect payment, its costs will be included in the claim. During that 30-day period, The Charis Clinic PLLC will be able to treat you on an emergency/urgent basis only.

8. Missed appointments and No Shows. Once an appointment is scheduled, it is reserved especially for you and you are responsible for the fee for that hour. **Unless you provide 48 hours advance** notice of cancellation, you will be expected to pay for it. Please note, insurance companies do not provide reimbursement for missed or cancelled sessions. You will, therefore, be held responsible for the **$100** late cancellation or no show fee.

9. Email or phone consultations. Our policy is to charge your insurance for phone conversations that last longer than 3 minutes. If you are paying cash, you will be charged $25 for phone lasting 5 to 15 minutes. Phone calls lasting longer than 15 minutes will be charged according to usual visit fees below. We prefer that you do not use email for consultations, as email is not HIPAA secure and does not allow the conversation necessary to address medical concerns. However, if email consultations require more than 3 minutes of our professional time they also will be charged at the above rates.

10. Medical forms or Letters. Our policy is to charge $40 for each form completed, and $10 per additional 10 minute increments of time required to complete forms.

11. **Limits of confidentiality.** The notice of privacy practices details how I use and disclose your protected health information. I want to highlight that in most situations, I can only release information about your treatment to others if you sign a written authorization that meets certain legal requirements imposed by state law and/or HIPPA. I may disclose information in the following situations when required by health insurers or to collect overdue fees as discussed elsewhere in this agreement. If you are involved in a court proceeding and a

request is made for information concerning the professional services I provided you, I must comply with a court order requiring disclosure. If you are involved in or contemplating litigation, you should consult with your attorney about likely required court disclosures.

Situations where I am permitted to disclose information **without** either your consent or authorization include if a government agency is requesting the information for health oversight activities. Other situations include if a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself, and if a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the patient's employer and the Department of Labor and Industries.

Other situations in which I am **legally required to take action to protect individuals from harm** include if I have reasonable cause to believe that a child has suffered abuse or neglect. The law requires that I file a report with the appropriate government agency, usually the Department of Social and Health services. Once a report is filed, I may be required to provide additional information.
If I have reasonable cause to believe that abandonment, abuse, financial exploitation or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate government agency, usually the Department of Social and Health Services.
If I reasonably believe that there is an imminent danger to the health or safety of a patient of any other individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can help provide protection.

12. **Professional Records.** The protected health information I keep about you constitutes your clinical record. Except in the unusual circumstance that I conclude disclosure could reasonably be expected to cause danger to the life or safety of the patient or any other individual or the person who provided information to me in confidence, you may examine or request a copy of your clinical record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. In most situations, I charge the $1/page for the first 20 pages, and $0.50 for every page thereafter, along with a $25 administrative fee. I may withhold your record until the fees are paid.

11. Usual & customary rates. Our practice is committed to providing the best treatment to our patients. Our prices are at or below usual and customary charges for our area. For uninsured clients, we offer a discount**. These fees must be paid in advance. You will place your card on file for your convenience.**

Note that there will be additional charges for EKG, phone calls, in-house labs, vaccines, and medication injections.*

12. We require that you place a credit card on file for balances that your insurance does not cover. Please see our Credit Card on File agreement attached below.

13. Scheduled Medications. ***We do not prescribe scheduled medications (such as opioids/narcotics, benzodiazepines, and stimulants) until a complete evaluation has been done, typically at least 3 one hour assessments.*** We also do not prescribe scheduled medications until we receive **all** necessary prior medical documentation for us to determine if this is an appropriate treatment for you. All patients on routine scheduled medications must agree to the terms of a written Medication Contract.

I have read and understand Charis Clinic's Financial, Payment, and Other Policies and agree to abide by them.

_____ _____

Signature of patient or responsible party **Date**

Printed Name: _____

CREDIT CARD ON FILE POLICY

Charis Clinic is dedicated to providing excellent and affordable care to our clients. Since the 2014 healthcare act and institution of higher deductible insurance plans, all clients are now required to present a credit card at the time of their appointment. This is consistent with many practices in our area.

Keeping your credit or debit card on file is a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your card will be put directly into a secure encrypted service and stored by the bank, just as when you check into a hotel. Only the last 4 digits of your card and expiration will be viewable by us.

Note that all of your rights with respect to the use of your card will remain in effect. This new policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination of payment. We will bill your claim to your insurance company who is required to send us and you an Explanation of Benefits (EOB), which will indicate your patient responsibility. After we have received the Explanation of Benefits your credit card will be charged as payment in full for the remaining Patient Responsibility. We will email you your receipt. Please ensure your card account is active and properly funded, as Charis Clinic will not be responsible for overdraft fees. This agreement will remain in effect for future credit cards you have provided to the clinic as well.

This authorization is required as a client of Charis Clinic.

__I request a call prior to my card being charged. Please note that if we do not hear from you, we will charge your credit card in 3 days. Please note that if you refuse to pay your charges from your EOB, additional charges of $10 per statement mailed, late payment charges, and collection action after 120 days will occur.

I authorize The Charis Clinic to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Last 4 digits:

I (we), the undersigned, authorize and request The Charis Clinic PLLC to charge my credit card, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance

company for services provided to me by The Charis Clinic PLLC. I have read Charis Clinic's credit card authorization policy and agree to the terms of this policy.

Patient, Patient 's Parent or Guardian Name: _____

Cardholder Name: _____

Cardholder Signature: _____

Date: _____

Charis Clinic AGREEMENT FOR EMAIL CORRESPONDENCE

Patient First and Last Name	Date of Birth	Phone Number
Address		Email Address

Certain patients may decide to use email to facilitate communication. Providers at Charis Clinic may communicate via email, but this agreement does not obligate Charis Clinic to communicate in this way. In general, phone communication and scheduled appointments are ideal.

Risks of using email

I want to use email to communicate to Charis Clinic Providers and staff about my/the patient's personal health care. I understand that Charis Clinic Providers and staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may affect the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.
- Email volumes may be so great that an email may be missed, or due to schedules may not be seen for many days.

Conditions for the use of email

I agree that I must not use email for medical emergencies, urgent situations, or to send time sensitive information to my/the patient's Providers.

I understand and agree that it is my responsibility to follow up with Charis Clinic or staff, if I have not received a response to my email within a reasonable time period.

I agree that the content of my email messages should state my question or concern concisely and clearly and include (1) the subject of the message in the subject line, and (2) clear patient identification including patient name, telephone number.

I agree that I will schedule an appointment if the issue is complex or sensitive.

I agree that email communications may be filed in the patient's permanent medical record.

I agree that messages sent may be delegated to another provider or staff member for response. Office staff may read or respond to emailed messages.

I agree that recommended uses of patient to provider email should be limited to appointment requests, prescription refill requests, requests for facility information, non-urgent health care questions, and updates to information or exchange of non-critical information such as immunizations, etc.

I agree it is my responsibility to inform Charis Clinic of any changes to my email address. I agree that, if I want to withdraw my consent to use email communications about my/the patient's healthcare, it is my responsibility to inform my/the patient's Provider and Charis Clinic's staff member only by written communication.

Understanding the use of email

I acknowledge that I have read and fully understand this consent form. I give permission to Charis Clinic Providers and staff to send me email messages that include my/the patient's personal health care information and understand that my email messages may be included in my/the patient's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/the patient, whenever necessary.

PRINT NAME (Patient or Parent/Guardian Authorized to give authorization)	SIGNATURE	DATE
If signed by person other than patient, print name, provide reason, relationship to patient, and description of their authority		

AUTHORIZATION TO LEAVE HEALTH INFORMATION BY ALTERNATE MEANS

Patient Identification

Name: _____
First Middle Last

Date of Birth: _____
Month/Day/Year

Authorization

I hereby authorize The Charis Clinic PLLC to leave **detailed, personal health information** by the following means: (please complete all that apply)

☐ Voicemail message at my home number: _____☐ Check if Preferred Method of Contact
(area code and number)

☐ Voicemail message at my work number: _____☐ Check if Preferred Method of Contact
(area code and number)

**☐ Voicemail message on my cellular phone: _____☐ Check if Preferred Method of Contact
(area code and number)

☐ Voicemail message at a different location: _____☐ Check if Preferred Method of Contact
(area code and number)

☐ Verbal message with my spouse or partner: _____☐ Check if Preferred Method of Contact
(NAME, area code and number)

☐ Verbal message with other family member: _____☐ Check if Preferred Method of Contact
(NAME, area code and number)

**☐ Email—Please sign a separate email consent form

☐ **I hereby authorize access to my own personal health record (You will need to enroll in the practice's EHR to access this system). This is available to adult clients.

☐ **I hereby authorize ☐ text and ☐ voice appointment reminder messages

I also authorize the exchange between the Electronic Health Record and state Immunization Registry.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify The Charis Clinic PLLC in writing should I wish to change one or more of the telephone numbers and/or contacts listed above.

_____ _____
Signature of Patient or Legally Authorized Representative Date Signed--Page 1 of 1—

**Important authorizations

The Charis Clinic PLLC
7631 212th St SW STE 101A
Edmonds, WA 98026
206-714-4476

AUTHORIZATION TO DISCLOSE/RELEASE PROTECTED HEALTH INFORMATION

- **I hereby authorize the release of protected health information (PHI) contained in my medical record to me, or to the party listed below. I understand that information released from The Charis Clinic PLLC is its property, and that a fee may be charged for the copying of any medical records.**
- **I understand that the information I am authorizing for disclosure/release to The Charis Clinic PLLC may be subject to re-disclosure and no longer be protected by the Privacy rule.**
- **I understand that I have the right to withdraw this authorization at any time, and that such revocation must be in writing. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Further, I understand that this authorization, without prior revocation, will automatically expire 90 days from the date of my signature unless I have stated otherwise.**
- **I understand that treatment will not be conditioned on signing the authorization (except treatment may be conditioned upon the individual signing an authorization when the treatment is related to research, or the treatment is provided for the purpose of disclosure to a third party—for example an independent medical examination).**

Patient:

Name _____

Former Name _____

Address, City, State_____

Date of Birth _____ Date(s) of Service _____

Individual or Institution Protected Health Information is to be Released FROM:

Name _____

Address _____

Phone Number _____

Fax Number _____

Individual or Institution Protected Health Information is to be Released TO:

Name _____ or Check if applicable: ☐ Charis Clinic

Address _____ 7631 212th St SW Ste 101A, Edmonds, WA 98026

Phone Number _____ (PH) 206-714-4476

Fax Number _____ (Fax) 425-732-4476

Purpose for Disclosure/Reason for Request: _____

Protected health information may include medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital records, clinician office chart reports, laboratory reports, dental records, pathology reports, therapy reports, hospital records, and other personal information.

Information to be Released: ☐ Entire medical record **Specific information: _____**

☐ Medical record from the following date_____ to the following date _____

I understand that my Provider needs my specific authorization to release information pertaining to the items listed below. I specifically authorize release of sexually transmitted diseases, including HIV/AIDs, chemical dependency, mental health information, reproductive health information, and records from other specialists UNLESS I have indicated below that I do NOT want disclosure of one of these below:

Do NOT disclose:

☐ Sexually Transmitted Diseases, including HIV/AIDS diagnosis/treatment _____ (initial)

☐ Chemical Dependency (Alcohol/drug diagnoses/treatment) _____ (initial)

☐ Mental Health Information (Psychological diagnoses/treatment) _____ (initial)

☐ Reproductive Health Information (including abortion) _____ (initial)

☐ Records received from other specialists _____ (initial)

Redisclosure: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of the Alcohol and Drug Abuse records which are protected by Federal Confidentiality Rules (42 CFR Part2). The Federal Rules prohibit the recipient 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 Part2.

I understand that The Charis Clinic PLLC cannot require me to sign this authorization in order to receive Health Care treatment, to enroll, or be eligible for benefits.

_____ _____

Signature of Patient or Legal Representative (mark below if legal rep) **Date**

☐ Parent ☐Legal Guardian ☐ Holder of Power of Attorney