



REGISTRATION FORM – Client Information

Date of 1st Appointment _____

Preferred Name: _____ Date of Birth: _____

Legal Name: LAST _____ FIRST _____

Gender identity: _____ Preferred Pronouns: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Insurance Provider: _____

Email address: _____

Contact Phone: (____) _____ - _____ Cell _____ Home _____ Other _____

Contact Phone: (____) _____ - _____ Cell _____ Home _____ Other _____

May we leave a message? Yes _____ No _____

May we say we are from Integrative Trauma Treatment Center? Yes _____ No _____

Would like you to receive reminders of your upcoming appointments?

_____ Email _____ Text Message

Preferred contact method: _____ Email _____ Phone Call

Can we discuss **appointments** and/or **billing** with anyone other than you?

Name: _____ Relationship: _____

Emergency Contact: Name: _____

Relationship: _____ Phone # _____

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Client Intake Agreement

Please initial next to each statement that you agree with.

- I acknowledge and fully understand the terms and conditions of the **Informed Consent for Services Rendered through ITTC.** _____
- I acknowledge and fully understand the terms and conditions of the **Safe Place Policies**

- I acknowledge and fully understand the terms and conditions of the **Medication Management Policies** _____
- I acknowledge and fully understand the terms and conditions of the **Electronic Communications Policies** _____
- I acknowledge and fully understand the terms and conditions of the **Cancellation and Coverage Policy** _____
- I agree to participate in **teletherapy sessions via telephone** if deemed clinically appropriate.

- I understand my **Rights and Responsibilities as a Client** at ITTC. _____

By signing below, you agree to participate in treatment services rendered by ITTC

(Client Name)

(Client Signature and Date)

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Authorization To Bill Health Insurance and Assignment of Benefits (AOB)

Consent for Treatment & Use of Records

By signing this form I voluntarily consent to treatment by the practitioners and clinical staff of Integrative Trauma Treatment Center hereafter referred to as (ITTC).

I also voluntarily consent to the use and disclosure of my protected health information (PHI) for treatment, payment, operations and other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) as well as the Family Educational Rights and Privacy Act (FERPA).

I understand that ITTC is an integrated clinic including medical and mental health services and that my record may be shared between those internal departments for treatment, billing, and accounting purposes.

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me. If financial resources are desired/needed, it my duty to ask ITTC about setting up a payment plan which is determined/ approved on a case by case basis.

In the event that this visit is based on a Worker's Compensation claim and my Worker's Compensation claim is not accepted, I agree to have the fees associated with services sent to my private health insurance company.

I understand that I am responsible for understanding information about my health insurance policy and providing such information to ITTC for correct billing.

I acknowledge that not all services or providers at our clinic are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of ITTC as an out-of-network provider, and/or my failure to provide my insurance card OR update our clinic with any new insurance or change in insurance.

Authorization (PLEASE COMPLETE):

I authorize payment directly to ITTC for services received. I accept responsibility for all charges if I do not have medical insurance. I have been informed that the services provided may not be covered by my insurance plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me.

By signing this document I am consenting to all of these terms and policies.

Patient Signature/Date

Guardian or Representative Signature/Date

Clinic staff signature/Date

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Integrative Trauma Treatment Center
811 NW 19th St Suite 102 Portland, OR 97209
p: 971-266-6910 f: 888-972-3623

**ACKNOWLEDGEMENT OF THE RECEIPT OF HIPPA NOTICE OF
PRIVACY PRACTICES**

I acknowledge that I have received a copy of this office's **HIPPA Notice of Privacy Practices**.

Patient Name (Please Print)

Patient Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

Parent ___ Guardian ___ Power of Attorney ___ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Office use only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **HIPPA Notice of Privacy Practices**. It could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement

___ A communication barrier prevented us from obtaining acknowledgment

___ The individual was unwilling to sign

___ Other: _____

Staff Member Signature

Date

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Client Name: _____ Date: _____

1. What are your mental health goals?

2. Why are you seeking care now?

3.

Are you having problems with any of the following
(Please check all that apply.)

<input type="checkbox"/>	Anger	<input type="checkbox"/>	Sleeplessness
<input type="checkbox"/>	Impulse control	<input type="checkbox"/>	Appetite, low
<input type="checkbox"/>	Relationship problems	<input type="checkbox"/>	Low energy
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Stress
<input type="checkbox"/>	Indecisiveness	<input type="checkbox"/>	Concentrating
<input type="checkbox"/>	Restlessness	<input type="checkbox"/>	Memory loss
<input type="checkbox"/>	Appetite, excessive	<input type="checkbox"/>	Suicidal thoughts
<input type="checkbox"/>	Lack of motivation	<input type="checkbox"/>	Crying frequently
<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	Oversleeping
<input type="checkbox"/>	Thought control	<input type="checkbox"/>	Weight control
<input type="checkbox"/>	Depressed Moods	<input type="checkbox"/>	Feeling worthless
<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Panic attacks
<input type="checkbox"/>	Too much energy	<input type="checkbox"/>	Worrying too much
<input type="checkbox"/>	Domestic violence	<input type="checkbox"/>	Hopelessness
<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	Racing thoughts
<input type="checkbox"/>	Too much guilt	<input type="checkbox"/>	Hearing Voices
<input type="checkbox"/>	Extreme tiredness	<input type="checkbox"/>	Comments:

4. It is important for us to know about your past as well as present situation. Childhood experiences shape our mental and emotional health. Thinking of the following items as they relate to your childhood and early adult life, please check all that apply.

	Frequent moves (of residence)		Sexual abuse
	Your mother was treated violently		Problems in school
	Serious physical illness in your family		Running away
	Repeated emotional humiliation		Physical neglect
	For part of your childhood you did not live with both of your biological parents		A member of your household was chronically depressed, suicidal, or mentally ill
	Physical abuse		Death of a family member
	A member of your household was imprisoned		A member of your household abused drugs or alcohol
	Emotional neglect		Abuse by parents or others

5. Changes in our lives often produce emotional stress. During the past year, have you experienced any of the following changes?

	Work problem or work changes		Eating disorder
	Family problems		Financial problems
	Personal health problems		Gambling problems
	Legal problems		Alcohol or drug problems
	Change in living situation		Relationship problems
	Sexual problems		Other significant life change.
	Death or illness of a family member (including chosen family)		

6. Mental health and physical health greatly influence each other. Please share any of the following information that may be related to today's visit:

a. Any medications prescribed by a doctor or over the counter drugs? To the best of your knowledge, please list all of your medications and dosages:

b. Any diagnosed health/medical conditions? Please share the details:

Substance Use

Have you ever used:	Yes	No	Last used (Date):	Method	Frequency	Amount
Alcohol						
Do you think you have a problem with alcohol?						
If no alcohol use, how long have you been sober?						
Marijuana/Hash						
Cocaine/Crack						
Crystal Meth /Amphetamine/Speed						
Heroin						
Codeine						
Barbiturates/Downers						
Tobacco						
Prescribed pain or anxiety medication						
Gambling						

7. What brings positivity to your life?

8. Please describe your image of a "safe space."

9. Is there anything else you would like me to know?



Integrative
Trauma Treatment Center

Integrative Trauma Treatment Center - 2130 SW Jefferson st. Suite 200 - Portland, Oregon 97201
P: 971-266-6910 E: scheduling@ittc.hush F: 888-972-3623

Informed Consent for Services Rendered through ITTC

Please read through the following informed consent agreement. What follows is a basic understanding between client and agency. In general, what are listed below are the responsibilities and obligations of your treatment team and also some expectations of you as the client. This document also contains important information about our professional services and business policies. Do not sign the informed consent unless you completely understand and agree to all aspects. If you have any questions, please bring this form back to your next session, so you and your clinician can go through this document in as much detail as is needed. When you sign this document, it will represent your agreement with each policy listed.

Services Offered:

Integrative Trauma Treatment Center offers individual, couples, and family therapy, group therapy, medication management, bodywork, and naturopathic work. While services are offered to all ITTC clientele, only some services are covered by insurance. More information about your particular insurance coverage can be obtained through officemanager@ittc.hush.com.

Voluntary Participation:

All clients voluntarily agree to treatment. Counseling involves a large commitment of time, money, and energy, so you should be thoughtful about the treatment team you select. In the first couple of sessions, you should be deciding whether your clinicians are right for you. If you feel it is not a good match with any clinician on your treatment team, we will be happy to assist you in finding a new clinician.

Client Involvement:

All clients are expected to show up to appointments on time, be prepared to focus on and discuss mental health goals and issues, and not attend while under the influence of mood-altering chemicals. All clients are expected to be open and honest so your treatment team can assist you with your goals. Counseling is not like a medical doctor visit. Instead, it calls for an active effort on your part. In order for therapy to be most successful, you are encouraged to work on things talked about both during your sessions and at home. Inconsistent attendance can negatively affect your therapy progress and can potentially lead to termination. Nonattendance will lead to termination. **If you arrive more than 15 minutes to your scheduled appointment time, you MAY not be seen. If you arrive more than 30 minutes late your scheduled appointment, you will NOT be seen.**

HIPAA Notice of Privacy Practices and Protected Health Information (PHI):

Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights with regard to use and disclosure of your Protected Health Information

(PHI). HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosures involving treatment, payment, and health care operations. The notice, which is included in your folder (and is viewable in the front lobby at ITTC), explains these disclosures and your rights to information in detail.

Confidentiality and Privilege:

The information and content shared in therapy (oral and written) will remain confidential, except in certain circumstances. Your information will not be shared with anyone outside of ITTC without your written consent. Your information is also privileged, which means that your treatment team is free from the duty to speak in court about your counseling unless you waive that right, or a judge orders it. Some examples of special circumstances in which we may release your PHI are as follows:

Public health risks, Health oversight activities (to monitor government programs), lawsuits and similar proceedings, law enforcement, deceased patients, organ and tissue donation, research, serious threats to health and safety, military, National Guard, inmates, workers compensation

Therapists and are also mandated reporters, required to report ongoing domestic violence, abuse or neglect of children, the elderly or people with disabilities

Regarding your protected health information, you have the right to: confidential communications, to request restrictions, inspection and copies (excluding mental health notes) with therapist and/or nurse practitioner approval when review would not be harmful. You have the right to request to amend records, an Accounting of Disclosures, to file a complaint, as well as to provide an authorization for other uses and disclosures.

Additionally, your therapist will at times consult with other therapists and/ or nurse practitioners contracted or employed by ITTC, through supervision and/or consultation. All staff working with ITTC sign a confidentiality agreement on a yearly basis and diligently adhere to all HIPAA policies and procedures.

Minors and Confidentiality:

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Payment of Services:

All payment arrangements are made through our billing department. We accept payment directly from insurance companies we contract with. To obtain information regarding therapy costs please call ITTC at 971-266-6910. Telephone conversations, site visits, report writing, consultation with other professionals, reading records, longer sessions, and travel time may also be charged for services received.

If you are utilizing a third-party payor other than insurance, the payor must sign an agreement that states they are responsible for all accrued expenses by the client.

Payment of services is the client's personal responsibility. This includes all co-payments, deductibles, and non-covered services, as dictated by insurance coverage, plus any collection costs for amounts personally owed. ITTC reserves the right to seek remuneration by any legal means. You (the client) are responsible for any fees associated with returned checks. In addition, a **\$50.00 fee will be charged by ITTC for any returned checks.**

Process, Risk and Benefits, and Guarantees:

When entering into trauma treatment it is important to establish safety, containment and boundaries before beginning to process traumatic memories and/or events. This timeline looks different for each client. You and your treatment team will establish a timeline that is clinically appropriate for your care.

There are risks to any form of treatment. In most cases the benefits outweigh the risks. Just as medications sometimes cause unexpected side effects, counseling can sometimes have unanticipated or adverse consequences. Treatment may increase symptoms and stimulate painful memories and uncomfortable feelings. Some benefits of therapy can include: a higher level of function, improved coping, solutions to specific problems, new insights into self, more effective means of communicating in relationships, symptomatic relief, improved self-esteem, and an improved quality of life.

Although many people do get better in therapy or with medication management, this is not guaranteed. Accordingly, your therapist or nurse practitioner makes no guarantee of results.

Bill of Rights (Code of Ethics):

The following client rights have been established by the Oregon State Board of Licensed professional Counselors and Therapists (OAR 833-060-0004(h)). Consumers of counseling or therapy services offered by Oregon Licensees & Registered Interns have the right: (A) To expect that a licensee has met the minimal qualifications of training and experience required by state law; (B) To examine public records maintained by the Board and to have the Board confirm credentials of a licensee; (C) To obtain a copy of the Code of Ethics; (D) To report complaints to the Board; (E) To be informed of the cost of professional services before receiving the services; (F) To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: (i) Reporting suspected child abuse; (ii) Reporting imminent danger to client or others; (iii) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies; (iv) Providing information concerning licensee case consultation or supervision; and (v) Defending claims brought by client against licensee. (G) To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services. You may contact the Board at the following address and phone number: Board of Counselors and Therapists, 3218 Pringle Rd SE #240, Salem, OR 97302- 6312. Phone (503) 378-5499

Termination of Therapy:

Any clinician on your treatment team reserves the right to terminate services at their discretion. Reasons for termination may include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, dual relationships, failure to participate in therapy, or if your needs fall outside of the scope of competence or practice. Termination with one clinician does not automatically mean termination of care or with the rest of your treatment team. Upon the decision to terminate services, your clinician may recommend that you participate in at least one termination session. This session is intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. **This session is not mandatory.** Your clinician will also attempt to ensure a smooth transition to another clinician by offering referrals to you.

Mediation and Arbitration:

All disputes or complaints arising out of, or in relation to services received shall be referred to mediation before, and as a pre-condition to the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of your therapist and you, the client. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved

controversy according to this agreement, will be submitted to and settled by binding arbitration in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed.

Frequency of Services:

Clients receive services based on their clinical level of need. After an initial assessment and level of care is determined by one of our clinicians, your treatment plan will be created with your clinician. Frequency of individual visits will be based upon your level of need, with the average being **once every other week**. However, all clients, regardless of level of need, have access to **group therapies**. If you feel there is a group you would like to see us offer, please let us know and we will do our best to add it. If you have any questions about how our services are offered, please feel free to contact the office manager or speak directly with your clinician.

Group Therapy:

Clients who engage in group therapy agree to follow ITTC Group Policies as well as the guidelines established by the facilitator.

Emergency Contact:

We request that you provide emergency contact information on your registration form. Providing us with this emergency contact, you are giving us consent to notify them in case of a mental health or medical emergency.

Acknowledgement:

By signing the intake agreement page, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions with your clinician and have had any questions answered to your satisfaction. You agree to the terms and conditions (policies) of this Agreement and consent to participate in mental health services with your treatment team understanding your rights and responsibilities as well as the risks and benefits.



Integrative
Trauma Treatment Center

*Integrative Trauma Treatment Center - 2130 SW Jefferson st. Suite 200 - Portland, Oregon 97201
971-266-6910*

Informed Consent for Teletherapy

This document is intended to inform you about aspects of teletherapy services. Teletherapy is defined as providing therapy through phone conversations. **Generally teletherapy is used only when absolutely necessary in instances such as transportation difficulties and/or lack of resources.** In some instances, such as snow days, we may offer phone sessions. Some therapists may use email and/or text to communicate regarding upcoming appointments.

Possible Misunderstandings:

Misunderstandings are possible with telephone and text based modalities (such as email and text messaging) because non-verbal cues are lacking and also because of potential connection issues, such as poor sound quality. Counselors gather important information through body language, vocal inflection, eye contact, and other verbal-cues. Therefore we ask you to be patient if your counselor asks for periodic clarification through the process of teletherapy.

Turnaround Time:

With communication such as email or voicemail there is generally a "lag" in response time. The counselor or the office manager will make every effort to respond to messages as soon as possible, however there might not always be a hastily turnaround time, especially in regard to email. If you are in a state of crisis or in an emergency situation please call the Multnomah County Crisis Line (800-716-9769), Lines for Life (800.273.8255), or call 911.

Privacy of Counselor:

Although the internet provides a possible appearance of anonymity, privacy is more of an issue online or over the phone than in person. The counselor has the right to privacy and may wish to restrict the use of any copies or recordings of their communications. Clients must seek written permission of the counselor before recording any portion of the session and/or posting any portion of the session on the internet.

Fees:

Teletherapy sessions are not covered by commercial insurance plans. All private pay and clients utilizing commercial insurance will be charged the full amount of a session regardless of the length of time.

Potential Benefits and Risks:

The potential benefits of receiving mental health services through teletherapy include the convenience for clients to potentially receive counseling remotely. Text-based chat has the advantage of providing time to compose a response, and being able to refer back to the message for reference.

There are potential risks involved with teletherapy related to the technology used and issues related to timeliness. For instance the potential risks involved with email may include messages not being received, confidentiality breached through unencrypted email, lack of password protection or leaving information on a computer that may be shared with others. Also visibility of the computer screen is an important consideration.

Safeguards:

All e-mails sent from ITTC will be sent using an encrypted e-mail server and will require a password to be opened. It is up to the client to keep their password secret. Text messages between ITTC and clients will be in reference to scheduling only. Please discuss any concerns you have with your counselor.

Disruption:

If there is ever a disruption of services, please call the main line at the Integrative Trauma Treatment Center to discuss how to proceed with the session. The counselor will attempt to re-connect with the client as soon as possible. If you are in a state of crisis or in an emergency situation please call the Multnomah County Crisis Line (800-716-9769), Lines for Life (800.273.8255), or call 911.

Acknowledgement:

By signing the intake agreement page, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions with your therapist and have had any questions answered to your satisfaction. You agree to the terms and conditions (policies) of this Agreement and consent to participate in psychotherapy with your therapist understanding your rights and responsibilities as well as the risks and benefits.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Your health Information Uses and Disclosures for Treatment, Payment, and Health Care Operations

Each time you visit Integrative Trauma Treatment Center (ITTC) for health care, a record of your treatment is made. This record contains such information as registration information, including identification and billing information, and treatment information, including symptoms, diagnoses, test results, and treatment plans. This record is referred to as your "medical record" or "health information," and includes both written and electronic records.

Under the Health Insurance Portability and Accountability Act of 1996 (a Federal Law also known as "HIPAA"), and federal regulations 42 CFR Part 2, ITTC providers are required to keep your personal and health information confidential and to provide you with notice of our legal responsibilities and privacy practices.

Definitions to help clarify some terms used throughout this notice:

"PHI" refers to *protected health information*, information in your health record that could identify you.

- "*Treatment, Payment and Health Care Operations*"

Treatment is the provision, coordination or management of your health care and other services related to your health care.

Payment is when reimbursement is obtained for your healthcare.

Health Care Operations are activities that relate to the performance and operation of ITTC.

- "*Use*" applies to activities within ITTC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. Your health care information is used:
 - To plan for your care and treatment
 - For communication among your health care professional
 - As a legal document describing the care you received
 - As a way for you or your insurance company to verify the services provide
 - For other similar activities that allow ITTC providers to operate efficiently and provide you with quality care.
- "*Disclosure*" applies to activities outside of Integrative Trauma Treatment Center such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Your clinician may use or disclose PHI for various purposes when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances an authorization will also be requested from you before releasing this information. In the cases of minors, legal guardians must give permission for ITTC to share information about the minor in their custody and care. An authorization will also be requested from you before releasing your

Psychotherapy notes. "Psychotherapy notes" are notes made about conversations during an individual, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) ITTC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insured the right to contest the claim under the policy.

- **Payment:** ITTC may need to give your health insurance plan information about your treatment in order to receive payment. ITTC may also tell your health insurance plan about treatment to obtain approval or to determine whether your plan will pay for treatment. ITTC may bill the person in your family who is responsible for payment of who pays for your health insurance.
- **Treatment:** ITTC providers may disclose your health information by phone, letter, fax, or computer to people not affiliated with ITTC who are involved in your medical care, such as your primary physician or a home health agency. An example of treatment would be when your clinician consults with another health care provider, such as your family physician or another clinician.
- **Workers Compensation:** If you file a worker's compensation claim, your records relevant to that claim to your employer or its insurer may be required to be released and your clinician(s) may be required to testify.
- **Appointment Reminders/ Additional Communications:** ITTC providers may use your health information to call you or send you a letter reminding you of an upcoming appointment. ITTC may also use your information to call or send you the results of tests or to give you other health communications.

III. Uses and Disclosures with Neither Consent nor Authorization

Your PHI may be released without your consent or authorization in the following circumstances:

- **Health Care Operations:** ITTC may use your health information for administrative activities, or for accreditation, certification, or licensing purposes. Your health information may be used to review the performance of ITTC providers involved in your care. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- **Health Oversight:** ITTC providers may disclose health information to agencies that monitor our compliance with local, state and federal law.
- **Medical:** If you are experiencing a medical emergency and the health information is deemed vital ITTC may release your health information to medical personnel. ITTC may release your health information to the Food and Drug Administration if they need to contact you about medications that have been recalled or mislabeled. In the event of a court order, ITTC providers may release health information in the event of making a report to a public health authority (i.e. communicable disease).
- **Law Enforcement:** ITTC providers may disclose health information to the correct officials if a crime is committed on ITTC property or against an ITTC employee. ITTC providers may disclose health information to the correct officials if you are in custody of a correctional institution or other law enforcement agency.
- **Research:** If scientific research is approved and your non-identifiable information is necessary for the study.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding, a lawsuit, or dispute, ITTC providers may disclose health information about you in response to a court order. This applies to subpoenas by the grand jury. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance, if this is the case.
- **Child Abuse:** If there is reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected, or have reason to believe that a child seen in the course of professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, ITTC clinicians must report this to the relevant county department, child welfare agency, police, or sheriff's department. Investigations by relevant county department, child welfare agencies, police or sheriff's department may result in request for treatment records and subsequent disclosure of PHI, including progress notes, to any agency investigating child abuse/neglect.
- **Adult and Domestic Abuse:** If your clinician believes that an elder person or an adult suffering from mental illness has been abused, exploited or neglected, such information may be reported to the relevant county department or DHS.
- **Serious Threat to Health or Safety:** ITTC may use and disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of others. ITTC clinicians must warn the third party and/or take steps to protect you, which may include instituting commitment proceedings.

IV. Patients Rights and Duties of Integrative Trauma Treatment Center Care Providers

Patients Rights:

- *Right to an Accounting of Disclosure-* You generally have the right to receive an accounting of disclosures of PHI. This list will not include: Disclosures made to carry out treatment, payment and health care operations; Disclosures made to you; Disclosures made with your authorization; Disclosures made six years or more before the date your request is received. To request and accounting of disclosures, make your request in writing to the ITTC Director.
- *Right to a paper copy-* You have the right to obtain a paper copy of the most current Notices or Privacy Practices upon request within a reasonable amount of time, even if you have agreed to receive the notice electronically.

Integrative Trauma Treatment Center's Duties:

- Treatment providers are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- ITTC reserves the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, ITTC Providers are required to abide by the terms currently in effect.

If policies and procedures are modified, you will be informed and provided a copy of the new practices if you request.

V. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on September 1, 2017

ITTC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI maintained and will provide you with a revised notice when changes are made.

VI. Contact and Complaint Information

Complaints: If you are concerned that privacy rights have been violated, or if you disagree with a decision made about access to your records, you may contact the Clinic Director, Sarah Dobey, LPC and discuss your concerns. If you would like to file a written complaint, grievance forms and instructions can be found at the front desk. If you file a complaint, you will not be punished, threatened, harassed, retaliated against, or subjected in any way to any negative consequences.

Integrative Trauma Treatment Client Rights and Responsibilities



ITTC recognizes the following Client Rights:

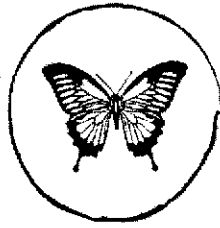
You have the right,

- To be treated with dignity and respect
- To have access to your treatment plan
- To choose from and receive available services and supports consistent with the plan
- To participate in the development of the plan
- To receive a copy of your treatment plan
- To have all services explained, including expected outcomes and possible risks
- To confidentiality and the right to consent to disclosure in accordance with OARS 107.154, 109.505, 179.507, 192.515, 192.507, and 42 CFR Part 2
- To give informed consent in writing prior to the start of services
- To access to your medical records
- To receive medication specific to the individual's diagnosed clinical needs
- To receive prior notice of service conclusion or transfer, unless it poses a threat to safety or health
- To be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation
- To have religious freedom
- To be free from seclusion and restraint
- To be informed of the policies and procedures, services agreements and fees applicable to the services provided.
- To have family involvement in service planning and delivery
- To file a grievance in regards to any and all services received
- To choose a provider and make changes as necessary
- To receive notice if your appointment has been cancelled in a timely matter.

ITTC expects the following Client Responsibilities:

You have the responsibility,

- To treat staff and other clients with dignity and respect
- To inform your provider of any changes in your behavior and/or physical or mental health status that could affect your care, including compliance with any prescribed medication
- To help your provider obtain past medical records
- To ask questions and get clarification regarding your diagnosis and suggested treatment plan
- To follow your provider's treatment recommendations
- To be prompt for scheduled appointments
- To cancel appointments if you are unable to keep them, so others may use the time slot
- To pay at the time of services rendered or inform Office Manager of financial hardships
- To be as open and honest with your provider as you can
- To inform your provider if you feel you are not making progress
- To adhere to the policies and procedures of ITTC
- To be aware of any insurance changes that may have occurred



Client Grievance Process & Feedback Form Acknowledgment

The Integrative Trauma Treatment Center welcomes feedback of any kind regarding the services we provide. If you are dissatisfied with anything regarding your experience here, you may make an informal complaint by talking directly with your clinician, the office manager, or clinical supervisor. You may also fill out a grievance and feedback form, which are available at the front desk. This form can also be used to provide any positive feedback or suggestions.

If you would like, you can email a grievance directly to the office manager (officemanager@itc.hush.com).

You will receive a phone call within one week to confirm your grievance was received and to discuss these concerns. Please note that you will only receive a call back in regard to a grievance (unless specified otherwise) and will only receive a call back if contact information is provided.



Safe Space Policies

Integrative Trauma Treatment Center is a trauma informed place for survivors and those embarking on their journey of healing through mental health. In order to maintain a welcoming and safe space, it is important for staff and guests to be mindful of their surroundings. The following policies are meant to be gentle reminders of how we can all work together to keep ITTC a safe place for everyone.

Group Therapy Policy:

When engaging in group therapy here at ITTC, please adhere to the following guidelines:

- Maintain confidentiality by not discussing group or group members outside of the group setting.
- Come on time and try to be present for others.
- Turn cell phones off during group
- Try to use preferred pronouns – ask if unsure.
- No racist, sexist, homophobic, or discriminatory comments will be tolerated.

Animal policy:

Service animals are welcome! All other animals are prohibited. The ADA authorizes the use of service animals in businesses (this would apply to businesses that are unrelated to housing or travel for companion animals as I understand the law) ONLY for the benefit of individuals with disabilities. A service animal is any guide dog or signal dog trained to provide assistance to a person with a disability. As defined by the ADA, dogs whose function is to provide comfort or emotional support DO NOT qualify as service animals. Service animals are trained working animals, not pets.

Attire policy:

Clients and staff agree to dress in a manner appropriate to the therapeutic setting. Any inappropriate or revealing attire may be grounds for removal from premises. In addition, please be considerate of others sensitivity to smells.

Waiting Room Electronic Policy:

Clients should refrain from out loud cell phone and other electronic use in the waiting area. Headphones should be used if a person is listening to something through an electronic device. Phone calls should take place outside of ITTC. If you need a private space to make a phone call, you may ask the receptionist if we have space available, but it is not guaranteed.



Electronic Communications Policy

Phone Communications:

Office staff are available by phone to address client needs. Scheduling and billing should go directly to the main office by phone. (971-226-6910 Option 2) Our staff works diligently to ensure clear communication with clinicians and can provide messages on your behalf. If you are experiencing an emergency, please contact 911, call Multnomah County crisis line, or go to your local emergency room.

Crisis line: 503-988-4888

Email Communications:

Our e-mail server is encrypted and is a good way to get in touch with administrative staff. The Office Manager can be reached at officemanager@ittc.hush.com.

For scheduling please email scheduling@ittc.hush.com.

Clinicians are generally not available between sessions to respond to e-mails. You are welcome to email your provider, but please be aware that in most cases you will not get a response and your clinician will discuss the content during your next session.

If you e-mail our staff, you are giving us permission to respond, even if the content contains personal medical or billing information, unless you specify otherwise in your original email.

Social Media:

Clinicians and staff of ITTC do not communicate with, or contact, any clients through any social media platforms, whether professional or personal in nature. ITTC does have a social media presence through Instagram, Facebook, and Twitter which is used purely for marketing purposes. If you comment, like, or subscribe to any ITTC content, please be advised that the privacy of those actions may be at risk.



Medication Management Policies

Medication Refill Requests:

During your medication management appointment you should receive prescriptions with enough refills to last until your next appointment. If you need a refill before your next appointment:

- 1) Contact your pharmacy for refills and allow up to **5 business days for processing**. The pharmacy will send a fax to your nurse practitioner requesting the refill.
- 2) Schedule a follow-up appointment **before** requesting medication refills. You may not receive medication refills if have not been seen recently by your prescriber.

Social Security Paperwork, Return to Work Forms, and Leave Forms:

To obtain the above forms, or any forms you may need from you provider please following the steps below:

- 1) Set up an appointment with your nurse practitioner and bring in **any needed paperwork** which will be filled out during your appointment.
- 2) ITTC will fax forms for you, but it is your responsibility to confirm that they are received by your employer, insurer or other agencies.

Letters and Brief Forms:

Provide your nurse practitioner with a written request for letters or brief forms and **include all needed information**, including who the form should be sent to and if it should be faxed, mailed or e-mailed. **Allow up to 7 business days for completion**.

Communications:

To contact your Nurse Practitioner, contact ITTC at 971-266-6910 option 2 or email frontdesk@ittc.hush.com **Please limit contact to one message**.

Cathy Ahern's patients may opt to call or text her cell phone at 503-887-3679.

Please allow **48 hours** for a returned response.

Crisis or Emergencies:

If you are experiencing a psychiatric emergency, please call the Multnomah County crisis line at 503-988-4888 or "911".

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Cancellation & Coverage Policy

Coverage & Co-Pays:

Please bring a copy of your medical card to each appointment. If you are no longer eligible for benefits, you will have the option to pay out of pocket or freeze services until proper arrangements have been made. We may provide transitional appointments if deemed clinically necessary. As a courtesy, we will check your benefits. However, this is not a guarantee of payment and **it is your responsibility to understand your coverage. Co-payments are due at the time of service and any outstanding balances may result in a payment plan or termination of services. You may be charged a \$5.00 service fee for any co-pay that is not paid at the time of service.**

Cancellations and No-Shows:

As a reminder, a minimum of 24-hour notice is required for rescheduling or cancelling an appointment. A late cancellation or no show has an impact on others. If we have enough notice of a cancellation, we can provide help to someone else.

To reschedule or cancel an appointment you can call 971.266.6910 option 2 or email: scheduling@ittc.hush.com. If a message is left on a different line or sent to a different e-mail you are subject to the "no-show" policy.

We charge a **\$155** late cancellation (less than 24 hours) or no-show fee. This fee is not covered by insurance and is due at your next appointment.

This fee is waived for OHP clients. However, if two (2) sessions are missed within a six (6) month period without adequate notification, services will be suspended and/or terminated. Services may be resumed but will be subject to the waitlist and your previous counselor and/or time may not be available.

Engagement Policy:

If clients consistently do not attend scheduled appointments at a rate of 50% or more, regardless of time of cancellation, ITTC reserves the right to terminate and refer out.

Payment Policy:

Payments are due at the time of service, **copays cannot be billed to you or to anyone else.** If you receive reimbursement for your payments we are happy to provide you with a receipt. If you are not utilizing insurance and are a private pay client, a private pay agreement must be signed and kept in your file. There will be no refunds for payments made for services rendered.

****all suspensions and terminations will include a referrals to appropriate services****

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