Anita M. Katz, PMHNP
5200 SW Macadam • Suite 312
Portland, OR 97239
ph. (503) 764-9508 fax (503) 764-9558

PATIENT INFORMATION: *Please complete all information requested.*

PATIENT'S FULL NAME | TODAY'S DATE

HOME ADDRESS

CITY | STATE | ZIP

HOME PHONE | WORK PHONE | CELL PHONE/PAGER

EMAIL

DATE OF BIRTH | SOCIAL SECURITY # | PLACE OF BIRTH

EMPLOYER | OCCUPATION

NAME OF RESPONSIBLE PARTY

HOME ADDRESS

CITY | STATE | ZIP

HOME PHONE | WORK PHONE | CELL PHONE/PAGER

DATE OF BIRTH | SOCIAL SECURITY # | DRIVERS LICENSE #

EMPLOYER | OCCUPATION

RELATIONSHIP TO PATIENT (IF NOT SELF)

SPOUSE'S/PARTNER'S NAME

HOME PHONE | WORK PHONE | CELL PHONE/PAGER

DATE OF BIRTH | SOCIAL SECURITY #

EMPLOYER

PERSON TO CONTACT IN CASE OF EMERGENCY: *(Other than immediate family member)*

HOME PHONE | WORK PHONE | CELL PHONE/PAGER

PATIENT'S PHYSICIAN | DATE OF LAST PHYSICAL

Reason for referral:

Whom may I thank for referring you?

Previous mental health care?

With whom?

Known allergies:

Current medications:

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INSURANCE INFORMATION: *Please complete all information requested in addition to your insurance card.*

PRIMARY INSURANCE		SECONDARY INSURANCE	
ADDRESS		ADDRESS	
CITY		CITY	
STATE	ZIP	STATE	ZIP
TELEPHONE		TELEPHONE	
GROUP #		GROUP #	
INSURED'S NAME		INSURED'S NAME	
POLICY #		POLICY #	
INSURED'S DOB		INSURED'S DOB	
POLICY EFFECTIVE DATE		POLICY EFFECTIVE DATE	

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my provider to:

1) Furnish my insurance company with any/all information requested concerning my present claim(s), including records if requested.

2) Bill my insurance company, and to accept payment from that company on my behalf, for all service from time to time relating to my care.

I acknowledge that I am responsible for all charges not covered by my insurance. I understand that any money received from me by Anita Katz, PMHNP, in excess of my bill will be refunded to me after completion of treatment. I also understand that I will be charged $100 for any appointment that I fail to keep or cancel within 24 hours prior to that appointment time and I agree to pay those charges in full.

PATIENT'S SIGNATURE (IF MINOR, PARENT OR LEGAL GUARDIAN'S SIGNATURE) _____ DATE _____

RESPONSIBLE PARTY'S SIGNATURE _____ DATE _____

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INFORMATION AND INFORMED CONSENT FOR TREATMENT

CONFIDENTIALITY

Communication between patient and therapist are confidential, even if the patient is a minor, and may be shared only for the purpose of consultation without the patient or patient/guardian expressed written consent. You will be informed in the event that any information is released without your expressed consent. Information may be released without written permission only 1) when a court order is received, 2) when there is reasonable cause to believe that child abuse or neglect has occurred, 3) when there is reasonable cause to believe that there is clear and imminent danger to self and/or others, 4) when a medical emergency exists, and 5) when required for insurance billing.

A release of information must be obtained before any information could be provided to, or requested from other individuals. Please download and fill out the Authorization Release Form for any provider(s) you have had previous evaluations with.

Patient rights - in accordance with the Oregon mental health code, all patients have the right to:

- Be treated with respect and dignity.
- Receive appropriate care and treatment, employing accepted methods and approaches most appropriate for specific problems and needs.
- Be informed of any alternative treatment methods available, if any.
- Be informed of risks, if any, associated with the treatment to be undertaken.
- Have an individualized service plan, reflecting problems and/or needs identified for or with the patient and /or family.
- Actively participate in the development or modification of one's treatment program.
- Refuse proposed treatment which the patient does not wish to receive unless otherwise ordered by the court.
- Know the name and credentials of the therapist.
- Have access to records.
- Lodge a grievance if there is reason to believe these rights have been violated.

PATIENT RESPONSIBILITIES

- Become actively involved in treatment goals and share periodic reviews with your therapist to assure each other of productivity and that we are working toward desired outcomes. If the patient is a minor, the parent(s) or guardian(s) of the child agree to actively participate in the healing of the family by establishing family treatment goals.
- Assume control of all payments to the therapist at the time of services.

- Notify your therapist at least **24 hours in advance cancellation** of any scheduled session. Emergency definitions are at the provider's discretion and include but are not limited to hospitalization, legal matters, but do not include transportation issues, minor illnesses (unless negotiated with provider), vacations, ineffective appointment tracking et al. Appointments are the patients and/or parents responsibility and reminders from the provider should not be expected. Failure to comply with the cancellation policy will result in a "missed appointment" fee which is a rate established by the provider. Please note that this fee is not the responsibility of your insurance company. Patient is responsible for all charges not covered by insurance and collection/attorney if applicable.

TELEPHONE MESSAGES AND EMERGENCY COVERAGE

The office phone is (503) 764-9508 and 24 hour paging in the event of an emergency at (503) 330-5586. Should an emergency arise, please follow the emergency procedures outline. In the unlikely event your call does not reach me, or in the event of a true medical emergency you need to call 911 and/or the mental health crisis line is (503) 215-7082.

PAYMENT AGREEMENT *(Range depending on services needed.)*

Initial Evaluation (50-90 minutes) ..... $250.00 - $395.00

Individual Therapy (50-60 minutes) ..... $220.00 - $335.00

Medication Management (20-30 minutes) ..... $105.00 - $210.00

Telephone Consultation: Consultation by telephone will not be charged to the patient if 15 minutes or less. If greater than 15 minutes, they will be billed at the patient's regular established hourly rate.

Co-payment of $_____or %_____ due at time of service, with insurance billed by therapist.

LENGTH OF TREATMENT

Therapy typically involves regular weekly sessions. Medication management appointments are usually 1-3 months. Duration of the treatment varies depending on the nature of the treatment and individual patient needs. When medications are indicated and the patient is a child, be aware that most psychiatric medications are not approved for use in children.

INFORMED CONSENT

I have read and understood the preceding statements, have had the opportunity to ask questions about them, and request and authorize Anita Katz, PMHNP, to provide my mental health services. A signature below indicates that the conditions listed above have been reviewed, understood, and agreed upon.

PATIENT'S SIGNATURE (IF MINOR, PARENT OR LEGAL GUARDIAN'S SIGNATURE) _____ DATE _____

RESPONSIBLE PARTY'S SIGNATURE _____ DATE _____

ANITA KATZ, PMHNP _____ DATE _____

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OFFICE AND FINANCIAL POLICIES

Thank you for asking me to participate in your health care. The following is an outline of my office policies. I ask that you take the time to read, initial and sign at the bottom of this form. Please ask any questions you may have before signing this agreement.

One of my billing goals is to minimize clients accruing large balances on their accounts, which may be a hardship later. Therefore:

___ 1. I ask that your appointments be paid in full until your annual deductible has been met. Thereafter, I ask for a co-Payment that is commensurate with your insurance policy at each scheduled visit.

___ 2. If you have no insurance coverage, I ask that you pay for each visit at the time of the appointment.

___ 3. If you have billing questions regarding your account you may contact my billing service, Metropolitan Health Provider's Billing Service. M.H.P.B.S. Will be billing your insurance company and sending you a monthly statement of your account. Please make sure that you update M.H.P.B.S. promptly of any changes to your address, phone number or insurance plan. M.H.P.B.S. Can be reached at (503) 249-0181.

___ 4. In the event that we are unable to collect on your account please be advised that any uncollectable fees may be turned over to an active credit corporation. In the event that your account is turned over to a third part for collections, the third party may be notified of the reason for service, i.e., Counseling. We will make every effort to work with you before this happens.

___ 5. Since rebilling accounts is costly, balances due over 30 days will be charged a $10 rebilling fee. All returned checks are subject to a minimum $10 service fee.

___ 6. Please understand that we can only discuss your account with the client on the account or the person(s) who signs as the responsible party on the account. We cannot discuss the account with spouses, parents or others unless they have signed to be the responsible party for the account or we have your signed permission.

___ 7. If you need to cancel an appointment for any reason, i.e., schedule conflicts, illness, childcare, I must have 24 hours notice. Appointments not cancelled 24 hours in advance will be charged to you at the no-show fee. Insurance will not pay for missed appointments. In the event that I will need to cancel your appointment, every effort will be made to advise you of the situation.

PATIENT'S SIGNATURE _____ DATE _____

RESPONSIBLE PARTY'S SIGNATURE IF PATIENT IS A MINOR _____ DATE _____

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CONSENT OF DISCLOSURE

(For the Usage and/or Disclosure of Protected Health Information)

I hereby give consent to my provider to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you on your behalf and delivered to the address at the bottom of this form. This may be delivered in person or by mail. It will only be effective when I actually receive it. Your cancellation will not be effective to the extent that others or I have acted in reliance upon this consent.

You have the right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. I am not required to grant your request, however, if I do, the restrictions will be obligatory to me.

My posted privacy policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review my posted privacy policy before you sign this consent.

I reserve the right to amend the terms of my posted privacy policy. You may obtain a copy of the current policy by requesting a copy from me.

PRINTED NAME OF PATIENT

SIGNATURE (IF MINOR, PARENT OR LEGAL GUARDIAN'S SIGNATURE)

PRINTED NAME OF LEGAL GUARDIAN

RELATIONSHIP

INSTRUCTIONS FOR COMMUNICATION OF PERSONAL HEALTH INFORMATION

I or my billing service, Metropolitan Health Providers Billing Service, may communicate personal health information to you by;

FAX #

ANSWERING MACHINE/VOICE MAIL#

AUTHORIZED PERSON(S):

How would you like to receive confirmation of appointments: ☐ text message ☐ phone call ☐ email
The confirmation is sent as a courtesy, please note, you are ultimately responsible for remembering the appointment.

The authorized person(s) listed below may____/may not____ schedule, cancel and confirm appointments for you.

PRINTED NAME OF PATIENT

SIGNATURE (IF MINOR, PARENT OR LEGAL GUARDIAN'S SIGNATURE) DATE

PRINTED NAME OF LEGAL GUARDIAN

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NO-SHOW POLICY FORM

Declaration of agreement regarding missed or canceled appointments.

I understand and agree to the following:

1. It is my responsibility to notify: Anita Katz at (503)-764-9508.

***24 Hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.**

2. I agree that I will be billed for the contracted rate of: **$100** in the event that I miss an appointment or fail to cancel 24 hours prior to the scheduled appointment.

3. I understand that repetitive missed appointments will result in loss of service with this practitioner.

PATIENT/GUARDIAN DATE

ANITA KATZ, PMHNP DATE

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