Carla Crockford, ARNP, BC

7600 NE 41st Street, Suite 310 phone (360) 571-2039
Vancouver, WA 98662 fax (360) 253-3196

Consent to Use or Disclose Clinical Information

I authorize Carla Crockford, ARNP to use and disclose the health care information for the purpose of ***Treatment*** (such as coordinating your care with your primary physician or other health care professionals), ***Payment*** (such as billing your insurance company and determining eligibility of your health benefits) and routine ***Health Care Operations*** (such as scheduling appointments or calling to remind you of an appointment).

This consent form is being provided to you with an attached ***Notice of Privacy Practices.*** Please review this ***Notice of Privacy Practices*** for additional information about the uses and disclosures of protected health care information described in this Consent prior to signing this Consent.

A summary of the ***Notice of Privacy Practices*** will be posted in my office indicating the effective date of the current copy of this document. As more fully explained in the Notice of Privacy Practices, you have the right to request restrictions on how your health care information may be used for treatment, payment, and routine health care operations. You also have the right to request a review of your records or to amend your records; this is more fully explained in the Notice of Privacy Practices.

Please verify that you received the ***Notice of Privacy Practices*** by initialing here: _____

I understand that I have the right to revoke this Consent, provided that I do so in writing, except to the extent that this office has already used or disclosed information prior to my decision to revoke consent.

_____ _____
Signature of Client Date

_____ _____
Signature of legal guardian (if client is a minor) Date

_____
Relationship to client (if client is a minor)

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Notice of Privacy Practices

This document describes how clinical and health care information may be used and disclosed and how you can get access to this information. Please review it carefully. This notice describes the privacy policies followed by this office and any practitioner who might provide "on-call" coverage for me, and applies to the information I have about your health and the services you receive from this office. If you have any questions or requests concerning this notice, please contact me.

I am required by current federal law, effective April 14, 2003, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) to give you this notice. It will tell you about the ways in which I may use and disclose protected health information about you and describe your rights and my obligations regarding the uses and disclosure of that information.

How I may Use and Disclose Protected Health Information (PHI):

By State law and the ethics of the mental health profession, I must have your written and signed consent to use and disclose health care information for the following purposes:
For Treatment: I may disclose health care information in order to provide better clinical services, i.e.; discussing your case with your primary physician or another practitioner for consultation purposes.
For Payment: I may use and disclose health information so that services may be billed and paid by you, your insurance company or a third party. It is my policy to release only demographics, diagnosis, date and type of service when I bill third party payers. If more information is required by a payer, I will request your written consent for that disclosure.
For Routine Health Care Operations: I may use health information about you in order to run my practice, i.e., appointment reminders. I may contact you as a reminder that you have an appointment. Please notify me if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contacts.

You may revoke your Consent at any time by giving written notice. Your revocation will be effective when I receive it, but will not apply to any uses and disclosures that occurred prior to that time.

If you are receiving substance abuse treatment, federal and state law require your written Authorization each time I release information. The Authorization will specify who is to receive the information, the purpose of the release of information, and a time period after which the Authorization will terminate. You may modify or revoke an authorization at any time.

Special Situations:
I may use or disclose health information about you without your permission for the follow purposes, subject to all applicable legal requirements and limitations:
To Avert a Serious Threat to Health or Safety: Based on professional judgment, I may use and disclose information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
Required by Law: Based on professional judgment, I may disclose health care information about you when required by federal, state or local law.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court order or subpoena, and I will use my professional judgment about the information to be disclosed.
Law Enforcement: I may release health information if required to do so in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
Family and Friends: In situations where you might not be capable of giving authorization, because you are not present or due to your incapacity or medical emergency, I may determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only information relevant to the person's involvement in your care.

Additional disclosures are permitted under HIPAA regulation. These will not be made without your authorization and consent. Once information leaves my office and becomes part of any data resource beyond my control, HIPAA permits disclosure in the following circumstances:
Research: Health information about you may be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address, or other information that reveals who you are.
Military, National Security, and Intelligence: If you are a member of the armed forces, or part of the national security or intelligence communities, military command, or other government authorities may require the release of health information about you. HIPAA also permits the release of information about foreign military personnel to the appropriate foreign military authority.

Workers Compensation: Health information may be released for workers compensation or similar programs. These programs provide benefits for work-related injuries.
Public Health Risks: Health information may be released in order to prevent or control disease, injury or disability; report births, deaths, suspected abuse or neglect, non-accidental injury, reactions to medications or problems with products.
Health Oversight Activities: Health information may be disclosed to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
Information Not Personally Identifiable: Health information may be disclosed in a way that does not personally identify you or reveal who you are.

Other Uses and Disclosures of Health Information:
This office will not disclose your health information for any purpose other than those identified in the previous sections without your specific written Authorization. You may also revoke your Authorization in writing, at any time. If you revoke your Authorization, I will not disclose any further information, but I cannot take back any disclosures already made with your permission. A separate written authorization is required for the release of information regarding HIV or substance abuse treatment. In order to disclose these types of records, I will provide a separate written release that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Protected Health Information:
Right to Review Records: You have the right to review your clinical, medical and billing records. You must submit a written request to me, the designated privacy officer, in order to inspect your health information. If you request a copy of the records, I may charge a fee for the costs of copying and/or mailing the records. I may deny your request to inspect, review or copy records in certain limited circumstances, such as when I believe exposure to this information may be detrimental to your mental health. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, I will select a licensed mental health care professional to review your request and my denial. The person who conducts this review will not be the person who denied the request, and I will comply with the outcome of the review. You do not have the right to review or copy private psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative proceeding.
Right to Amend: If you believe the health records about you are incomplete or incorrect, you may ask me to amend the information. You have the right to request an amendment when the information is kept by this office. To request an amendment, you must submit a clear statement of the requested amendment to the designated privacy contact. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask to amend information that:
- I did not create.
- Is not part of the health information that I keep.
- You would not be permitted to review, inspect, or copy.
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures I have made of clinical information about you for purposes other than treatment, payment, and routine health care operations. To obtain this list, you must submit your request in writing. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). I may charge you for the costs associated with providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Right to Request Restrictions: You have the right to request a restriction or limitation on the health care information disclosed about you for treatment, payment or health care operations. You have the right to request limits on disclosures, such as asking that I not call you at your office, or that I not communicate with family members.
Right to Request Confidential Communications: You have the right to request that I communicate with you about clinical matters in a confidential way, such as asking that I only contact you at home.
Right to a Paper Copy of this Notice: You have the right to a paper copy of this privacy notice. Even if you agreed to receive it electronically, you are entitled to a paper copy.

Changes to this Notice:
I reserve the right to change this privacy notice, and to make the revised notice effective for any medical or clinical information I receive in the future. I will post a summary of the current privacy notice, including its effectiveness date, in my office. You are always entitled to a copy of the notice currently in effect.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

Carla Crockford ARNP BC

Policies & Procedures

Appointments:

Appointment times vary in length depending on the service and complexity. Initial evaluations are 60 minutes; psychotherapy sessions are generally 30-60 minutes; medication management visits are 10-40 minutes.

Your appointment is held exclusively for you. ALL NON-EMERGENCY CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE WILL BE CHARGED A LATE CANCELLATION FEE. You are responsible for payment of that charge as your insurance company will not pay for a missed session. I have a 24 hour voice mail which allows you to cancel at anytime. That number is 360.571.2039.

FEES:

60 minute initial evaluation 90791 or 90792	$350.00
30 minute psychotherapy with patient/family member with E&M service 90833	$150.00
45 minute psychotherapy with patient/family member with E & M service 90836	$200.00
60 minute psychotherapy with patient/family member with E &M service 90838	$250.00
Office visit, evaluation & management (E&M) 10 minutes established patient 99212	$100.00
Office visit, E & M, 15 minutes established patient 99213	$150.00
Office visit E & M 25 minutes established patient 99214	$250.00
Office visit E & M 40 minutes established patient 99215	$300.00
Office visit E & M new patient 60 minutes 99204/ 99205	$350.00/$400.00
Interactive complexity code in addition to psychotherapy, E&M visit 90785	$20.00

PAYMENTS:

1. Insurance co-payment and deductible are due at time of service.
2. Payment for returned checks must be made immediately
3. Seriously past due accounts may be sent to collections or legal action may be taken. You agree to be responsible for any collection or court costs or attorney fees.

EMERGENCY CALLS:

Either office staff or phone mail service is available on a 24 hour basis. Messages taken are returned in a timely manner. In case of an emergency the office staff will attempt to reach your provider or the on call provider. The crisis line for Clark County is 360.696.9560 and is accessible for emergencies.

Confidentiality:

By law all information you share during the evaluation, psychotherapy and medication management visits remains confidential. Such information can only be released with the written consent of the patient, or in the case of a minor, the parent or guardian.

There are 3 exceptions: 1. Suspected child, elder, and adult dependent abuse. 2. Potential suicidal behavior. 3. Threatened harm to another including unwillingness to inform individuals with whom you may be involved intimately that you are HIV positive

Insurance companies will require a diagnosis and possibly periodic report of your treatment. Your contract with your insurance company may give them authorization to obtain treatment notes. Any release of confidential information will be discussed with you.

I HAVE READ THE ABOVE POLICIES AND AGREE WITH THE TERMS

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

CARLA CROCKFORD ARNP, BC

7600 NE 41st Street, Suite 310
Vancouver, WA 98662
360-571-2039 - Phone
360-253-3196 - Fax

Acknowledgment of Confidential Information to Primary Care Physician

Patient Name: _____

Date of Birth: _____

I acknowledge that information about my mental health outpatient treatment may be shared with my primary care physician and behavioral healthcare professional to coordinate care if necessary and appropriate.

Patient Signature: _____ **Date:** _____

Primary Care Physician: _____

City: _____ **Phone:** (____)_____ **FAX:** (____)_____

****

The above named patient is being seen by me, Carla Crockford, ARNP, on an outpatient basis.

My initial diagnosis is:_____

Treatment consists of:_____

_____

If you are prescribing medications or have other information that might relate to this treatment , please feel free to mail or fax a summary to **(360) 253-3196**. If you need additional treatment information, or wish to coordinate this patient's treatment with me, please feel free to call me at **(360) 571-2039**.

Date form sent to PCP: _____ Sent by: _____

Carla Crockford ARNP

Financial/billing policy

Thank you for choosing me as your health care provider. I am committed to your treatment being successful as well as comprehensive and helpful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of my financial policy which I require that you read and sign prior to any treatment or assessment services. Please ask any questions you may have before signing this agreement.

FULL PAYMENT OR CO PAYMENT OF YOUR FIRST VISIT IS DUE AT THE TIME OF SERVICE. IF YOU HAVE NO INSURANCE, FULL PAYMENT IS DUE AT THE TIME OF EACH APPOINTMENT.

Regarding Insurance:

I accept the assignment of insurance benefits beginning with your second visit. However, I do require co-payments to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. I cannot bill your insurance company unless you bring all the insurance information. Your insurance policy is a contract between you and your insurance company. I am not a party to that contract. In the event I do accept assignment of benefits, I ask that you contact your insurance company for exact benefits. Any amount that I quote you is an estimate only and is provided by your insurance company. I do not guarantee payment from your insurance company. If your insurance company has not paid your account in full within 90 days, the balance will be automatically due and payable by you. Please be aware that some, and perhaps all of the services provided may be non-covered services or may be considered to be reasonable and/or necessary under the Medicare program and/or other medical insurance.

Usual and Customary Rates:

My practice is committed to providing the best treatment for my patients and I charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determinations of usual and customary rates.

Minor Patients:

I cannot bill third parties except for insurance companies. This includes situations of billing a natural parent that does not reside with the patient if the patient is a minor. All co-payments for office visits of a minor are due from the responsible party at the time of service.

ALL ACCOUNTS OVER 90 DAYS ARE CHARGED INTEREST AT THE LEGAL RATE OF 1 ½% PER MONTH ON THE UNPAID BALANCE WITH A MINIMUM CHARGE OF 50 CENTS REGARDLESS OF WHETHER INSURANCE IS PENDING OR NOT.

Missed Appointments:

Unless cancelled 24 hours in advance, my policy is to charge for missed appointments at the rate of a normal office visit. You may leave messages on my voice mail 24 hours a day. Emergency cancellations less than 24 hours will be handled on an individual basis.

ALL RETURNED CHECKS ARE SUBJECT TO A FEE OF $25.00

_____

Signature of patient or responsible party

Carla Crockford ARNP

7600 NE 41 St Suite 310

Vancouver, WA 98662

Name _____ DOB_____

I understand that Carla Crockford is not a contracted provider at this address for Medicare, Medicaid, Division of Medical Assistance Programs (DMAP) formally known as Office of Medical Assistance Programs (OMAP), Oregon Health Plan (OHP), Crime Victims or Labor & Industry.

Carla Crockford will not bill any of these agencies. I understand that I cannot bill any of these agencies for any services received by her at this address.

These services may be available through a contracted provider. If you choose a contracted provider, these services will be paid for up to the allowable amount.

The estimated fee for the first appointment is $300.00. The estimated fee for follow up appointments is $150.00. I understand that I am responsible for any and all fees for services provided.

I have disclosed all of my insurance information, including any coverage through any of the agencies listed above.

_____ _____

Signature Date

Carla Crockford ARNP

Patient Registration Form

Please complete all sections

Patient's full name_____age_____DOB_____M/F Marital M S D W
Street Address_____City_____State_____Zip_____
SS#_____Employer_____Work phone_____
Home phone_____ Cell phone_____ other _____
May we leave message for you at home yes____ no____ May we leave messages at work yes___ no___
Primary Care Provider_____phone_____
Email address _____

Person responsible for account if other than above

Name_____relationship_____phone_____DOB_____
Address_____City/State_____zip_____
Employer _____Employer phone_____

Primary Insurance

Insurance Company_____ phone_____
Address _____City/state_____ zip_____
Name of insured _____DOB_____ Group_____
ID #_____SS#_____
Insured Employer_____ Address_____

Secondary Insurance

Insurance Company_____ phone_____
Address_____city/state_____zip_____
Name of insured _____DOB_____ group_____ ID_____
Employer _____ city/state_____ zip_____

Assignment of Insurance Benefits and Agreement to Pay

I have completed the above to the best of my knowledge. If the information changes I will notify Carla Crockford. She is not liable for incorrect information. Carla Crockford ARNP has my permission to bill insurance company(ies). I authorize the release of any medical information necessary to process these claims. I authorize medical benefits to be paid to Carla Crockford ARNP

_____ _____

PATIENT SIGNATURE/LEGAL GUARDIAN DATE

MEDICAL HISTORY FORM

NAME: _____ DATE: _____
DATE OF BIRTH: _____

PAST MEDICAL AND PSYCHIATRIC TREATMENT

Major operations and dates:

_____
_____
_____
_____

Major Illnesses and dates:

_____
_____
_____

Psychotherapy or counseling? Yes _____ No _____
If yes, who with _____
Psychiatric hospitalization? Yes _____ No _____
If yes, when, where, and for what?

_____
_____

Previous medications for psychiatric problems

Medication name Dose Response (side effects and how helpful)

_____
_____
_____

Present prescription medications of any kind

Medication name Dose Who is prescribing

_____
_____
_____

Are you taking any of the following:

OTC (Non-prescription) medications? _____
Herbal, naturopathic, or homeopathic medications? _____
Vitamins or nutritional supplements? _____

Medications to which you are allergic

Medication Reaction

_____
_____
_____
_____

List your current health care providers

_____
_____
_____

SYSTEMS REVIEW

Check if you have had any of these symptoms or problems to an unusual or significant degree:

___ Headache
___ Fainting
___ Dizziness
___ Lightheadedness
___ Ear troubles
___ Sinus problems
___ Stuffy nose
___ Allergy
___ Hoarseness
___ Trouble seeing
___ Double vision
___ Trouble hearing
___ Cough
___ Wheezing
___ Pleurisy
___ Shortness of breath
___ Night sweats
___ Chest pain
___ Cough up blood
___ Trouble swallowing
___ Indigestion
___ Heartburn
___ Stomach pain
___ Vomiting blood
___ Blood in stool
___ Dark (black) stools
___ Change in bowel habits
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Irregular heartbeat
___ Ankle swelling
___ Increased urination at night
___ Shortness of breath if lying down
___ Leg pain with walking
___ Joint pain
___ Back pain
___ Numbness
___ Varicose veins
___ Hot flashes
___ Nervous
___ Depressed
___ Difficulty sleeping
___ Decreased appetite
___ Weight change
___ Difficulty concentrating
___ Difficulty urinating
___ Pain with urination
___ Blood in the urine
___ Frequent urination
___ Impotence
___ Frigidity
___ Problems with intercourse

For women only

Date of last menstrual period _____
Form of birth control, if any _____
Please check if you have any problems with:
Heavy periods ___ PMS ___ Painful periods ___ Irregular periods ___ Spotting ___

Is there any other information that you feel would be important in helping to understand you and your problems?

_____
_____
_____
_____
_____

Medications to which you are insensitive or intolerant

Medication Reaction

_____

_____

_____

Do you use any of the following? Please list usual amount and frequency and/or make check under "Past Use" if not currently using but did in past.

	Current	Past Use
Tobacco or tobacco products		
Coffee		
Caffeinated beverages		
Alcohol		
Marijuana		
Heroin (or other narcotics)		
Stimulants (crank, cocaine)		
Hallucinogens (example: LSD)		
Other drugs (prescription or non-prescription)		

FAMILY HISTORY

List any blood relatives that have or have had the following psychiatric problems:

Depression _____

Suicide _____

Schizophrenia _____

Bipolar disorder (manic depressive) _____

Panic disorder _____

Obsessive-compulsive disorder _____

PTSD (post traumatic stress) _____

ADHD (attention deficit hyperactive disorder) _____

Eating disorders _____

Alcoholism _____

Chemical dependency _____

"Nervous breakdown" _____

Any other psychiatric problem _____

Please list any medications and responses to the medications relatives have received for their condition:

Relative Medication Dose Response Problems with medication

_____

_____

_____

Check off if any of the following have occurred in your blood relatives:

___ Heart disease
___ Kidney disease
___ Seizure
___ Thyroid problems
___ Diabetes
___ Neurological disorders
___ Hypertension (high blood pressure)
___ Glaucoma
___ STD (sexually transmitted diseases, for example, syphilis, AIDS)
___ Any other major medical conditions