

Intake Information 11-18 year:

Parent/Guardian to complete

Date completed: _____ Form completed by: _____

Teen's name: _____ Date of Birth: _____ Age: _____ Gender: _____ Race: _____

Address: _____ City: _____ State: _____ Zip: _____

Teen Telephone (home) _____ (cell) _____ Email: _____

May I leave a message for teen at home? Yes No cell? Yes No via email? Yes No

Mother's Name _____ Date of Birth: _____ email: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's phone home _____ work _____ cell _____

May I leave a message for mother at home? Yes No work? Yes No cell? Yes No via email? Yes No

Father's Name _____ Date of Birth: _____ email: _____

Address: _____ City: _____ State: _____ Zip: _____

Father's phone home _____ work _____ cell _____

May I leave a message for father at home? Yes No work? Yes No cell? Yes No via email? Yes No

Names of those that you live with and their relationship to you:

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Please list any siblings not living in your home:

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Emergency Contact _____ Relationship _____ Phone number _____

How did you hear about me? _____ email/address of reference _____

Please tell me why you are seeking care for your teenager? (more room at the end if you need more space)

When did this problem start?

Does this problem occur at Home at School with Friends Other _____

Describe any recent changes that may contribute to the problem: _____

Check all of the behaviors and symptoms that you have observed in your teen in the past three months:

<input type="checkbox"/> Depression	<input type="checkbox"/> Irritable	<input type="checkbox"/> See things others do not
<input type="checkbox"/> Fear of hurting yourself	<input type="checkbox"/> Angry	<input type="checkbox"/> Hear things others do not
<input type="checkbox"/> Fear of hurting someone else	<input type="checkbox"/> Sad most of the time	<input type="checkbox"/> Difficulty getting to sleep
<input type="checkbox"/> Fire-setting	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Difficulty staying asleep
<input type="checkbox"/> Legal problems	<input type="checkbox"/> Frequent mood changes	<input type="checkbox"/> Wander during night
<input type="checkbox"/> Traumatic event	<input type="checkbox"/> Feeling anxious/fearful	<input type="checkbox"/> Frequent nightmares
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Tearful	<input type="checkbox"/> Drug/alcohol use
<input type="checkbox"/> Harmful to animals	<input type="checkbox"/> Easily distractible	<input type="checkbox"/> Tics/involuntary movements
<input type="checkbox"/> Argumentative	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Pre-occupied with sex
<input type="checkbox"/> Unable to keep friends	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Secretive	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Frequent complaints of illness
<input type="checkbox"/> Lying	<input type="checkbox"/> Lack confidence	<input type="checkbox"/> Appetite changes
<input type="checkbox"/> Stealing	<input type="checkbox"/> Lost interest in activities/friends	<input type="checkbox"/> Recent weight loss or gain
<input type="checkbox"/> Aggressive toward others	<input type="checkbox"/> Prefer to be alone	<input type="checkbox"/> Throwing up after eating
<input type="checkbox"/> Destructive to property	<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Trouble with your parents
<input type="checkbox"/> Access to weapons	<input type="checkbox"/> Confused a lot	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Overly energetic	<input type="checkbox"/> Electronics addiction
<input type="checkbox"/> Helplessness	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Picky eater
<input type="checkbox"/> Blame others	<input type="checkbox"/> Repetitive thoughts	<input type="checkbox"/> Self-injury
<input type="checkbox"/> Irresponsible	<input type="checkbox"/> Repetitive behaviors	<input type="checkbox"/> Other: _____

Are your problems affecting any of the following?

- | | | | |
|--|--|--|----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Work/School Housing | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances | <input type="checkbox"/> Health |
| <input type="checkbox"/> Recreational activities | <input type="checkbox"/> Sexual activity | | |

Previous Evaluations by:

Conclusions

Helpful?

Date

_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Developmental History:

When did child enter your home? Birth Step at age ____ Adopted at age ____ Foster at age ____

Born at how many weeks gestation? ____ Weight at birth ____ lbs ____ oz Vaginal ____ Cesarean ____

Problems with labor or birth? _____

Time in NICU or other early hospitalizations? _____

Exposure to alcohol, drugs, tobacco, medication in pregnancy? Yes No Describe: _____

Difficulty bonding to child? Yes No Describe: _____

Prolonged separation in first year? Yes No Describe: _____

What was child's disposition like as an infant? _____

Any health problems as an infant or toddler? Yes No Describe: _____

Head injury or trauma? Yes No Describe: _____

Does he/she have a partner? Yes No Length of relationship ____ months, Comment _____

Environmental History: (please check all that apply currently or in the past):

<input type="checkbox"/> Death in the family	<input type="checkbox"/> Financial stress
<input type="checkbox"/> Unemployment of self or parent	<input type="checkbox"/> Frequent moves
<input type="checkbox"/> Parental illness	<input type="checkbox"/> Emotional abuse
<input type="checkbox"/> Crime victim	<input type="checkbox"/> Parental separation or divorce
<input type="checkbox"/> Violence at home	<input type="checkbox"/> Violence between family members
<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Teen doesn't wear seatbelt
<input type="checkbox"/> Alcohol abuse <input type="checkbox"/> self or <input type="checkbox"/> parent	<input type="checkbox"/> Guns in the home
<input type="checkbox"/> Drug abuse <input type="checkbox"/> self or <input type="checkbox"/> parent	<input type="checkbox"/> Other: _____

Mental Health History:

What psychiatric medications has your teen taken in the **past?** (not current meds)

Name	Dosage/Frequency	Purpose	Effect and Side effects of medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Alcohol and Drug History:

Does your teen use any of the following substances?

	Current	Past	How much?	How often?	Comment
Alcohol					
Marijuana					
Tobacco					
Drugs					
Other:					

Family history of substance abuse? Yes No By whom? _____

Employment History: (16 and older)

Does your teen have a job that earns money? Yes No Where? _____

How many hours per week? _____

Academic History:

Is your teen currently enrolled in school? Yes No If No, why not? _____

What school does your teen attend? _____

How well is he/she doing academically? _____

How well is he/she doing socially? _____

What extracurricular activities is he/she involved in? _____

School problems you are aware of? _____

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Low grades | <input type="checkbox"/> Feels threatened | <input type="checkbox"/> Victim of bullying/teasing | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Special classroom | <input type="checkbox"/> Social/behavioral problems | <input type="checkbox"/> Underachievement | <input type="checkbox"/> Overachievement |
| <input type="checkbox"/> Failing grades | <input type="checkbox"/> Suspensions/expulsions | <input type="checkbox"/> Skipping/poor attendance | <input type="checkbox"/> IEP |

Legal History:

Has your child ever had a legal problem or been involved with the police? Yes No

If Yes, please describe: _____

Court orders? Arrests? Pending legal charges? Court officer? _____

Medical History:

Does your teen have any ongoing medical problems? Yes No

If Yes, please describe: _____

Does your teen have any allergies (food, medication, other)? Yes No

If Yes, please describe: _____

Current prescription medication/ Over the counter medications/ Herbal remedies / Nutritional Supplements:

Name	Dose/how often?	Purpose	Any side effects?	Provider
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

	Teen's History	Teen Currently	Family History	Relationship to teen?	Comment
Thyroid Disease					
Anemia					
Liver Disease					
Kidney Disease					
Heart Disease					
Diabetes					
Asthma					
Stomach Intestinal					
Accident					
Cancer					
Epilepsy					
Pain					
High Cholesterol					
High Blood Pressure					
Anxiety					
Depression					
Bipolar					
ADHD/ADD					
Autism/Asperger					
Schizophrenia/Psychosis					
Learning Disability					
Surgeries					
Alcohol					
Drugs					
Cigarette					
Caffeine					
Other:					

Maggie Alexander, PMHNP
(503) 523-9629

3095 SW 118th Ave Beaverton, OR 97005

Primary Provider Name: _____ **Address:** _____

Phone number: _____ **Fax number:** _____

Previous hospitalization for mental health problems? Yes No Please explain circumstance: _____

Suicide Attempt? Yes No If Yes, when _____ where _____ **got help?** Yes No

History of Abuse (physical____, sexual____, emotional____)? Comment _____

Diet on a typical day _____

Exercise in a typical week _____

Height: _____ **Weight:** _____ **Weight Range in past 3 years:** _____ to _____ **Ideal Weight:** _____

Sleep: Ave # of hrs/night _____ **Go to bed @** _____ **Get up @** _____ **# of wakings** _____

Sleep aides/meds _____

Nightmares Yes No **Comment** _____

Electronics: Ave # of hrs/day _____ **Favorite kinds he/she uses** _____

Friends: Ave # of hrs/week _____ **Favorite things they like to do** _____

Hobbies he/she has done in the past year: _____

More details about what brought you and your teen in to see me today:

What are you most hoping to accomplish by coming to see me?

Other Questions or Comments?

Parent/Guardian Signature

Date

Relationship to Teen

Date

**Notice of Privacy Practices and Professional Disclosure Statement
Receipt and Acknowledgment of Notice**

Client Name: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Maggie Alexander, PMHNP's Notice of Privacy Practices and Professional Disclosure Statement. I understand that if I have any questions regarding the Notice or my privacy rights I can contact Maggie Alexander, PMHNP.

Signature of Client

Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____ Relationship to
Client: _____

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

This form will be retained in your medical record

POLICY STATEMENT

Confidentiality

Communication between client and provider/therapist is confidential, even if the client is a minor, and may be shared only for the purpose of consultation without the client or parent/guardian present. You will be informed in the event that any information is released without your express consent. Information may be released without written permission only: 1) if a court order is received, 2) when there is reasonable cause to believe that child/elder 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 signed before any information can be provided to or requested from other individuals or agencies.**

Client Responsibilities

- Become actively involved in the treatment goals and share periodic reviews with your provider to assure each other of productivity and that we are working toward desired outcomes. If the client is a minor, the parent(s)/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 provider at the time of the appointment
- Notify the provider no less than 48 hours in advance of any cancellations.
- Failure to comply with the cancellation policy will result in a missed appointment fee. Insurance companies do not typically reimburse patients for these costs and the client will be directly held responsible for these costs.

Telephone Messages and Emergency Coverage

You may reach me or leave a voice-mail for me at 503-530-9766. I work part-time and only return calls on days I am in my office. If I am away for an extended time period, the message will direct you as to who is providing coverage for my patients. In the event of an emergency, call 911 or go to the nearest emergency department. I do not carry a 24-hour pager.

In the event of a crisis, you may contact:

- Emergency (police, fire, ambulance) 911
- Multnomah County Crisis Line 503-988-4888 or 1-800-716-9769
- Washington County Crisis Line 503-291-9111
- Clackamas County Crisis Line 503-655-8401
- Clark County Crisis Line 360-696-9560
- Portland Women's Crisis Line (domestic violence) 503-235-5533
- Rape Crisis Center 503-640-5311
- Poison Control 503-494-8968 or 800-452-7165
- Oregon Council on Alcoholism and Drug Abuse Hotline 800-923-4357
- Cascadia 24-hour Urgent Walk-In Clinic (Located at 2415 SE 43rd Ave – near Division)

Prescription Refills

- Refills of medication usually are written at the time of your scheduled appointment.

- Prescription refills are not emergencies, and must therefore be handled during regular business hours- Mon-Friday, 9 am-5 pm.
- Please contact your pharmacy and have them fax me a refill request at 503 992-6625 allowing 72 hours for refills to be completed on business days.

Payment Agreement

1. It is your responsibility to know if your insurance covers my services. Charges not covered by your insurance are your responsibility. It is also your responsibility to notify me of any changes in insurance coverage.
2. It is customary to pay for professional services when rendered. Payments must be made or services may be discontinued.
3. If you have a balance on your account, you will receive a statement. All accounts are due and payable within thirty days of notification. If payment is not received within 60 days, a late fee will be applied. If a client fails to be responsible for the account, and it is necessary to place a delinquent account into the hands of a collection agency/attorney, the client agrees to pay all court costs affixed by the court.
4. If you have a question regarding the payment of fees, please discuss this with me.
5. If you late cancel (cancel with less than 48 hour notice) or miss an appointment, you will be charged the total appointment fee. Insurance companies typically do not pay these fees and it will be your responsibility to pay these costs. Additionally, insurance companies do not typically pay charges for phone sessions or written documentation. You will be asked to pay for these charges directly.
6. All checks are to be made out to Maggie Alexander, NP.
7. There is a \$35 service charge for NSF/Returned checks.

Length of Treatment

Individual therapy typically involves regularly scheduled weekly or bi-weekly sessions.

Medication management sessions are more frequent in the beginning, or after any changes are made, and then typically occur monthly or bi-monthly. Duration of treatment varies depending on the nature of the treatment and individual client needs. When medications are used in psychiatry, please be advised that they are frequently used "off-label" meaning that they are used to control symptoms other than what the FDA originally approved the medication to treat. This is especially true in children. Patients must be seen at minimum every 90 days to be considered active patients with Maggie Alexander, PMHNP. Should you not schedule an appointment for a period of 90 days and make no arrangement in writing with this provider for said time, you will no longer be considered an active client of Maggie Alexander, PMHNP and therefore have terminated treatment. Also, if you "no show"/ "late cancel" for two consecutive appointments or "no show"/ "late cancel" for one appointment and do not reschedule within thirty days, you will be considered to have terminated treatment with Maggie Alexander, PMHNP.

Grievance Procedure

I encourage you to discuss your complaint with me directly to resolve the problem/issue. You may also contact your insurance company. Additionally, I am licensed through the Oregon State Board of Nursing. It also has a process for hearing complaints. You may contact the Oregon State Board of Nursing at: 17938 SW Upper Boones Ferry Road, Portland, OR 97224-7012, or at (971) 673-0685.

Maggie Alexander, PMHNP
(503) 523-9629

3095 SW 118th Ave Beaverton, OR 97005

Client Endorsement

After reading these, policies please sign below. By signing you express that you understand these policies. You can request a signed copy for your records. I have read this policy statement and understand its provision.

PRINTED CLIENT*: _____

SIGNED: _____

DATE: _____

*IF CLIENT 14 years or older, must be signed by client

PRINTED NAME of PARENT / GUARDIAN: _____

SIGNED: _____

DATE: _____

INFORMED CONSENT FOR EVALUATION AND TREATMENT

1. You have the **RIGHT TO BE INFORMED REGARDING The terms UNDER WHICH TREATMENT OR EVALUATION WILL BE PROVIDED.** Policies related to charged; billing third party payers, appointments, emergencies, and coverage for when your provider is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed.
2. You have the **RIGHT TO CHOOSE THE BEST TREATMENT AND PROVIDER.** There are a variety of professionals offering counseling, psychotherapy, psychiatric evaluation. There are also a number of different approaches to working with human issues. It is your right and responsibility to choose the treatment and provider that best matches your needs. You also have a right to a detailed explanation or any treatment or procedure your provider may choose to use including the risks involved and the side effects if any. If you believe you are not receiving the treatment you require, then raise this concern with your provider and she will work with you to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.
3. You have the **RIGHT TO KNOW THE QUALIFICATIONS AND TRAINING** of your provider. You may request a provider information sheet from your provider. If you have concerns, complaints, or believe a breach of professional conduct has occurred, you may contact the provider directly. If the difficulty is not resolved, you have the right to make a formal complaint to the Oregon State Board of Nursing.
4. You have the **RIGHT TO REFUSE TREATMENT OR TO STOP TREATMENT** at any time and for any reason. In the case where a minor is the patient/client, then parent(s) or legal guardian has the right to refuse or stop treatment for the minor. You also have the right to refuse or stop evaluations. Your provider also has the right to refuse or terminate treatment, in which case you will be provided with alternatives. If you have concerns regarding your treatment or wish to discontinue, you are encouraged to discuss this with your provider.
5. You have the **RIGHT TO CONFIDENTIALITY.** This means that what you tell your provider and what is contained in your clinical file will not be repeated or released by the provider to anyone else without your expressed permission (i.e. by a signed release of information). You have the right to see and have access to the contents of your file. You have the right to discuss your own therapy or evaluation with anyone you choose, including another provider.
6. For minors 14-17 years old, psychiatric mental health nurse practitioners may provide treatment to a fourteen year-old without consent of his/her parent. Oregon law requires your provider to have your parents involved in treatment before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. Maggie Alexander, PMHNP does not need to involve your parents in treatment if you have been sexually abused by your parent or if you are emancipated. It is the policy of Maggie Alexander, PMHNP to notify the parents on or before the third session. By signing this informed consent document you:

- a. Authorize Maggie Alexander, PMHNP to contact your parents and to give them a summary of your treatment.
- b. Authorize your provider to use her best clinical judgment on when to inform you parents of important issues related to your treatment.
- c. Authorize Maggie Alexander, PMHNP to release your treatment records to your parents upon their request. It is the policy of Maggie Alexander, PMHNP to require both you and your parents to sign any release of information to anyone other than your parents.

There are, however, some limits and exceptions to complete confidentiality:

- a. **CHILD OR ELDER ABUSE:** Generally, providers are required by law to report any known or suspected cases of child or elder abuse to the Children’s Services Division or other appropriate state agency.
- b. **VIOLENCE:** If a provider learns that someone is about to kill or to do harm to someone else, she will do her best to warn the intended victim.
- c. **SUICIDE:** If a provider learns that a client intends to harm her/himself, the provider will breach confidentiality to the extent necessary for the client’s protection.
- d. **NON-CUSTODIAL PARENTS:** By law, non-custodial parents can gain access to their children’s records pertaining to treatment or evaluation.
- e. **SUPERVISION:** Your provider may present your case in clinical staffing and also periodically review and discuss your treatment.

CONSULTATION: Occasionally, it is in your best interest for your provider to consult other providers regarding your treatment (e.g. medication issues, family issues, obtaining another’s expert opinion, covering emergency phone calls, etc.). This will be carried out with the utmost consideration for your privacy.

INSURANCE: Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment, or other relevant information in order to authorize services or process claims. A release of information will be obtained for this if you are utilizing an insurance company.

I have read and understand my rights and responsibilities as outlined in Maggie Alexander, PMHNP informed consent for evaluation and treatment form. Furthermore, by signing this form, I consent to receive mental health services to be provided by Maggie Alexander, PMHNP.

PRINTED NAME: _____

DATE: _____

SIGNED*: _____

*If client 14 years or older must be signed by client.

PRINTED NAME of PARENT / GUARDIAN: _____

RELATIONSHIP TO CLIENT: _____

SIGNED: _____

DATE: _____

Maggie Alexander, PMHNP, LLC

Psychiatric Mental Health Nurse Practitioner

Authorization to Use and Disclose Protected Health Information (PHI) to Insurance

Client Name _____ DOB ____/____/____
Street Address: _____
City, State, Zip Code: _____
Telephone Number: _____ Social Security Number: _____

I, the undersigned, hereby authorize Maggie Alexander, PMHNP, to send information to billing representatives. I, the undersigned, hereby authorize Maggie Alexander, PMHNP and its billing representatives to send information to:

Insurance Company: _____ Subscriber: _____
ID Number: _____ Group/Policy #: _____

Secondary Insurance : No Yes:
Insurance Company: _____ Subscriber: _____
ID Number : _____ Group/Policy #: _____

I, the undersigned, certify that I have Neither Medicare or Medicaid.

Purpose of Disclosure (please initial):

____ Authorize to bill insurance named above and coordination of billing issues between Maggie Alexander PMHNP its billing representatives

Information to be released is (please initial):

- | | |
|---------------------------------------|------------------------------|
| ____ Diagnosis | ____ Psychotherapy Notes |
| ____ Psychosocial History | ____ Chemical Dependency |
| ____ Treatment plan or summary | ____ HIV or AIDS information |
| ____ Psychological Evaluation/Reports | ____ Other |

Required Statements:

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under Federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment from Maggie Alexander, PMHNP, unless the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make the disclosure. If I do not sign this authorization, I understand that Maggie Alexander, PMHNP, will not be able to bill my insurance. I will be required to pay "Cash Pay" based on the fair and customary rate for all mental health treatment at Maggie Alexander, PMHNP.

I may revoke this authorization in writing at any time. If I do so, the information described may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made cannot be undone. If I revoke this authorization, I understand I will enter into the "Cash Pay" arrangement described above as Maggie Alexander, PMHNP, will not be able to bill my insurance.

This written authorization is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this authorization shall expire twelve months from the date signed. Other (specified): _____

I have read this authorization and understand it.

Signature of Client Date

Subscriber Signature Relationship to Client Date DOB of Client
*If patient is 14 years or older form must be signed by patient.

Subscriber SSN if subscriber is a minor: _____

Maggie Alexander, PMHNP, LLC

Psychiatric Mental Health Nurse Practitioner

3095 SW 118th Ave Beaverton, OR 97005 Telephone: 503 523-9629 Fax: 503 992-6625

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO THE PRIMARY CARE PROVIDER

I, _____, hereby authorize Maggie Alexander, PMHNP to receive information from and/or send information to the clinician indicated below. This release pertains to the following types of information: medical history, mental or physical conditions or treatment, including information relating to my mental health diagnosis and/or substance abuse diagnosis and treatment to my primary care provider.

Clinician Name: _____

Clinician Address (Street, City, and Zip): _____

Clinician Phone Number and/or Fax Number: _____

This authorization for release extends to the care and treatment the client received during:

- All dates of service or
- Service between _____ and _____

This information may be used for the following purpose(s):

- Evaluation, assessment and/or treatment and/or
- Ongoing coordination of treatment and/or
- Other: _____

The information to be released is:

- Diagnoses
- Psychological Evaluations/Reports
- Medical Evaluations
- Treatment Plan or summary
- Chemical Dependency Information
- Other: _____

This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this consent shall expire:

One year from date signed or Upon termination of treatment or Other: _____

Signature of client, parent, or legal guardian

Date signed

Witness

Date signed

FOR Maggie Alexander, PMHNP TO COMPLETE:

Primary Care Provider: _____

The purpose of this letter is to notify you that your patient _____, (DOB: _____) has begun mental health services with me. I believe it is important to coordinate mental health medical services with the medical care, which you are providing. I will contact you as needed to discuss any concerns or questions that I have regarding our client's mental health issues. Please send any information that you deem important to the mental health services being provided or call. Thank you. DSM-V Diagnosis:

Axis I: _____

Axis II: _____

Known Current Psychotropic Medications: None _____

Medical Condition/s: _____

Treatment (Therapy) Modalities: Individual Family Couples Group Other:

Estimated Length of Treatment: 3 months 6 months 9 months Other:

Please help monitor these risks: None Suicidal Ideation Homicidal Ideation Poor self-care

Coordination of Care Issues: _____

Maggie Alexander PMHNP

Date

Maggie Alexander, PMHNP, LLC Psychiatric Mental Health Nurse Practitioner

3095 SW 118th Ave Beaverton, OR 97005 • Telephone: 503 523-9629 • Fax 503 992-6625

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name _____ DOB ____/____/____
Street Address: _____
City, State, Zip Code: _____/_____/_____
Telephone Number: _____

I authorize Maggie Alexander, PMHNP, LLC

Check appropriate spaces and initial and give complete name and address:

To give health records to: Name: _____
 To receive health records from: Street Address: _____
 To verbally exchange health information with: City, State, and Zip Code: _____
Telephone: _____
Fax Number: _____

For the purpose of continuing care or: _____

All information in chart
 Specific information to be released: _____
if such information exists:
 Mental health related information HIV/AIDS related records
 Drug/alcohol diagnosis, treatment or referral information Genetic testing information

As indicated below, the authorization for release extends to the care and treatment the client received during:

All dates of service Service between _____ and _____

Required Statements:

This authorization will expire in one (1) year or upon (insert date or event) _____

I may revoke this authorization in writing by presenting my written revocation to Maggie Alexander, PMHNP, LLC.

The revocation will not apply to information that has already been released in response to this authorization. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. Maggie Alexander PMHNP, LLC is not responsible for the cost of copies.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information under federal or state law.

Signature of Client* _____ Date _____

Signature of Personal Representative _____ Date _____

Relationship to Client _____

*If patient is 14 years or older form must be signed by patient

Maggie Alexander, PMHNP-BC

3095 SW 118th Ave Beaverton, OR 97005 p. 503 530- 9766 f. 503 992- 6625

CREDIT CARD AUTHORIZATION FORM

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, _____ on behalf of _____,
authorize Maggie Alexander, PMHNP to charge my credit card for professional services rendered to
myself or my child as follows:

Please Initial Where Appropriate:

_____ Recurring charges for services in the amount of \$ _____

_____ Per Visit

_____ Per month on the _____ day of each month per our signed payment arrangement plan

_____ I understand and agree that my card will be charged the full fee of the scheduled appointment for
cancellations with less than 48 hours' notice and for appointments I miss without notice as agreed to in the
office policies I signed.

_____ I understand and agree that my card will be charged for balances of charges not paid by me or my
insurance as outlined in the office policies I signed (all visits, phone calls, letters, emails, and consults).

_____ I understand this form is valid until I cancel the authorization in writing. I will not dispute charges
("charge back") for sessions I have received or appointments I missed according to the above policy. I further
understand that I am responsible for updating my credit card information in the event that it should change,
and that I am responsible for any fees incurred for a declined credit card transaction.

_____ I understand and agree that my card may be charged without me being present and that a receipt of
payment will be sent to me within 48 hours of charges being placed on my card.

Charges will appear on your credit card statement as Maggie Alexander, NP

Card #: _____

Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (the 3 digit code on back of card by signature line): _____

Billing Address: _____

City _____ State _____ Zip _____

EmailAddress: _____

Signature _____

Printed Name _____

Date _____