Mental Health Solutions, LLC
CHILD/TEEN PATIENT REGISTRATION FORM
PATIENT INFORMATION (NAME MUST MATCH INSURANCE CARD)

DATE___/___/___

NAME _____ BIRTH DATE ___/___/___ AGE _____

MARITAL STATUS: SGL MAR DIV SEP WID SOCIAL SECURITY NUMBER _____

STREET _____ CITY _____ STATE _____ ZIP _____

MAILING ADDR (or Same) _____CITY _____ STATE ____ ZIP_____

OCCUPATION _____ EMPLOYER _____

HOME PH (____) _____ MAY WE LEAVE A DETAILED MESSAGE? Yes No

MOBILE PHONE (____) _____ MAY WE LEAVE A DETAILED MESSAGE? Yes No

EMERGENCY CONTACT (____) _____ NAME _____ RELATIONSHIP _____

REFERRED TO CLINIC BY _____ OTHER FAMILY MEMBERS SEEN HERE _____

NAME OF PRIMARY CARE DOCTOR _____PRIMARY DOCTOR PHONE _____

RESPONSIBLE FINANCIAL PARTY (IF APPLICABLE)

NAME _____ RELATIONSHIP TO PATIENT _____

MAILING ADDR (or Same) _____ HOME PHONE (____) _____

MOBILE PHONE (____) _____ WORK PHONE (____) _____

-

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD AT CHECK IN)

PRIMARY INSURANCE _____ SUBSCRIBER'S NAME _____

SUBSCRIBER BIRTH DATE___ /___/___ YOUR RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER

Patient ID NUMBER _____ Group# _____

SECONDARY INSURANCE _____ SUBSCRIBER'S NAME _____

SUBSCRIBER BIRTH DATE___ /___/___ YOUR RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER

Patient ID NUMBER _____ Group# _____

Reason for visit today?

Credit Card Type: VISA / MC Credit Card Number: _____ Expiration Date: _____

Name on card: _____ Billing Address of card: same as STREET or MAILING or RESP PARTY?

Or BILLING ADDR _____CITY _____ STATE _____ ZIP_____

The above information is true to the best of my knowledge. I authorize payment of medical benefits to Mental Health Solutions LLC. I also authorize the release of any medical information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for my account.

_____ _____

PATIENT/ GUARDIAN SIGNATURE DATE

Mental Health Solutions, LLC
FINANCIAL & ADMINISTRATIVE POLICIES
(*Please make yourself a copy*)

RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received or been allowed to view a copy of Mental Health Solutions LLC, Notice of Privacy Practices as required by HIPAA. This notice describes how Mental Health Solutions LLC, may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. **Initial_____**

PATIENT PAYMENT POLICY

· It is the policy of Mental Health Solutions to collect all payments and co-payments due from patients at the time of service. All benefits estimated to be the patient portion will need to be paid prior to sessions.

· If your insurance claim denies payment due to incorrect personal information or incorrect insurance information that you have provided intentionally or unintentionally, you will be charged and payment in full will be due immediately. Credit cards on file will be charged immediately unless other prior arrangements have been made.

· If your account or any account that you are responsible for is sent to a collection agency or to small claims court for nonpayment, you will face possible dismissal from care and will be charged collection agency fees and any court fees.

· It is your responsibility to know the services covered by your insurance and if your insurance does not cover these services, you will be responsible for payment.

· If you do not have insurance, you will be asked to pay at the time of service.

· A photo ID will be requested from all patients.

· New patients who do not supply their insurance card and/or who do not know what their specific mental health benefits are (i.e. deductibles, copay, percentage covered, number of visits allowed/year, whether treatment plan is required) must pay in full at the time of service. Adjustments will be made later.

· If you are required to have a referral or authorization for office services, it is your responsibility to get one. **Initial_____**

FLEX SPENDING PLANS/REIMBURSEMENT PLANS

· If you have a Flex Spending Plan or other type of Reimbursement Plan, you will be required to pay the portion which is the patient's responsibility prior to any session and will be provided with a receipt to use for reimbursement from you plan. If your plan provides you with a "credit card" for payments, we will be happy to accept this form of payment. **Initial ____**

CANCELLATION POLICY

· Our office requires a *48 hour business day cancellation notice. This does not include weekends.*

· No shows and cancellations without proper notice for all appts previously made ahead or the same day of, except in cases of medical emergency where notice is impossible, will require a **$100 fee** which will be due immediately and credit card charged This is the patient's responsibility and is **not reimbursed by insurance**. In some situations, a phone visit may be allowed in lieu of personal visit to clinic. If a patient repeatedly misses or cancels an appointment, the patient may be dismissed from the practice. **Initial_____**

COURT APPEARANCES/TRAVEL TIME/CREATION OF REPORTS: $300/hr**. Initial_____**

RECORDS REQUEST CHARGE: I charge a flat administration fee of $25 for each request. Records requests are free to your other medical providers. **Initial_____**

RETURNED CHECK CHARGE

· Mental Health Solutions, LLC will charge the patient account $25.00 for any returned checks to cover the cost of the associated bank charges. **Initial ____**

I have read, understand and agree to abide by the above policies.

Patient Signature:_____ Date:_____

PRINTED NAME_____

MEDICATION MANAGEMENT POLICY
Mental Health Solutions, LLC
Satu Woodland PMHNP
(Please initial each paragraph and make yourself a copy)

As a specialist, I get many referrals from other practitioners to help people they may feel ill-equipped to help. In doing specialty work, my training and services go beyond that of a general practitioner. General practitioners prescribe medication. They may make decisions for medication based on very short blocks of time with a patient. They often do not do, or are not trained to do, extensive psychiatric evaluation or counseling/ therapy. This is where my services differ. Considering the complicated psychosocial nature of my clients' problems, I need time with my clients to provide counseling/therapy and make proper, specialized decisions about medication and treatment. I do not believe this can be done responsibly without frequent regular contact. Therefore, I have established the following policies:

1) All clients under my care who require medication management services but do not require/want weekly counseling must come in at a minimum for a check-in *every 3 months; and more often initially*. I would prefer a regular 45 minute session to optimally evaluate progress and provide some regular minimal counseling. If the full 45 minutes is a hardship because of financial or work requirements, then a 30 min session will be the bare minimum time required. There are few exceptions to this rule which I reserve the right to decide.

2) If a client cannot make the scheduled appt for whatever reason, I need to be contacted immediately to reschedule. (Also, remember without 48 hour notice, the client will be charged directly—I am unable to charge insurance for this.) All medication management services are to be given during our sessions and **not** via internet or phone. I will occasionally make exceptions but may charge you for the time.

3) Refills: To request refills, please note I take care of these only during business hours. I require a 72 hour turn-around time, not including weekends.

4) My benzodiazepine (controlled substances) policy: I consider these rescue meds and I prescribe them rarely and only if a patient is working with me to get off them which includes regular therapy with me or another counselor. For any of the controlled medications, please note, if you lose the prescription, you are out of luck till our next refill. If someone steals your prescription, please file a police report and bring to me.

5) I reserve the right to discontinue our professional contract if these policies are not respected.

I have read and understand these policies and agree to follow them.

Patient Signature _____ Date: _____

Printed Name _____

To be completed during session

Satu H. Woodland PMHCNS

Coordination of Care between Health Care Providers and Release of Information

I want to inform you that _____ was seen by me for the treatment of:
(Member name)

DSM-5, ICD-10 and/or medical diagnosis:_____

Date of appointment: _____

Summary: _____

_____

_____

_____

The treatment plan consists of the following modalities:

___ Individual psychotherapy ___ Group psychotherapy ___ Family psychotherapy

___ Psychological testing ___ Other (specify) ___ Medication management (see below)

Current medication(s) (dosage, frequency and delivery)

_____

_____

_____

_____

_____

The following medication was or will be started (indicate medication and dosage): _____

_____

Estimated length of treatment: _____

Satu H. Woodland, PMHCNS _____
(Print provider name) (Signature) (Date)

Notice to recipient: This information has been disclosed to you from records protected by federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients.

Child/Teen Intake Questionnaires

Parents, in order for us to be able to fully evaluate your child or teenager, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your child or teenagers medical chart it is ok to refrain from putting it in this information. Thank you!

PATIENT IDENTIFICATION

Name _____ First Appointment Date _____
Birth Date _____ Age _____ Sex _____
School _____ Grade _____
Religion _____ Natural Mother _____
Race _____ Natural Father _____
Address _____
City _____ State _____ Zip _____
Home Phone # _____ Parent Work # _____ (specify) mom or dad
Who is the child currently living with? _____

REFERRAL SOURCE

Referral Source _____
Referral Address _____ Phone # _____
Do we have your permission to release information to the referring professional when it is appropriate?
Yes ___ No ___

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?

What do you want this clinic to do for your child, yourself or your family?

_____

_____

_____

Name:_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

_____

_____

MEDICAL HISTORY

Current medical problems/medications: _____

_____

Past medical problems/medications: _____

_____

Other doctors/clinics seen regularly: _____

_____

Any history of head trauma? (describe): _____

_____

Ever any seizures or seizure like activity? _____

Any periods of spaciness or confusion? _____

Prior hospitalizations (place, cause, date, outcome): _____

_____

Prior abnormal lab tests, X-rays, EEG, etc.:_____

_____

Allergies/drug intolerances (describe):_____

Present Height _____ *Present Weight* _____

Current Stresses (please list current factors that are a source of stress in the family)

_____

_____

FAMILY HISTORY

Family Structure (who lives in the current household with the child, please give relationship to the child):

_____

_____

_____

Current Marital Situation/Satisfaction of Parents _____

_____

_____

Family Development (include marriages, separations, divorces, deaths, traumatic events, losses, etc.)

_____

Natural Mother's History: age_____ outside work _____

School: highest grade completed _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems _____

Name:_____

Natural Mother's History Continued

Childhood atmosphere (family position, abuse, illnesses, etc)_____

_____

Has mother ever sought psychiatric treatment? Yes ___ No ___

If yes, for what purpose?_____

Mother's alcohol/drug use history_____

Have any of mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations?

(specify)_____

_____

Natural Father's History: age_____ outside work _____

School: highest grade completed _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

_____

Has father ever sought psychiatric treatment? Yes ___ No ___

If yes, for what purpose?_____

Father's alcohol/drug use history _____

Have any of father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

(If Applicable)

Step or Adopted Mother's History (indicate which): age_____ outside work _____

School: highest grade completed _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

_____

Has step-mother ever sought psychiatric treatment? Yes ___ No ___

If yes, for what purpose?_____

_____

Step or adopted mother's alcohol/drug use history _____

Step or Adopted Father's History (indicate which): age_____ outside work _____

School: highest grade completed _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

_____

Name:_____

Step or Adopted Father's History Continued
Has step-father ever sought psychiatric treatment? Yes ___ No ___
If yes, for what purpose?_____
_____
Step or adopted father's alcohol/drug use history _____

Siblings (names, ages, problems, strengths, relationship to patient)
_____
_____
_____
_____

CHILD'S DEVELOPMENTAL HISTORY
Prenatal events:
Parents attitude toward pregnancy _____
Conception--ease _____ planned _____ unplanned _____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc_____

Birth and Postnatal period:
Birth weight ___ Length ___ Labor duration ____ Delivery: vaginal __ C section __ Problems _____
APGAR scores (if known) _____ Any jaundice? Yes ____ No ____ Time in hospital _____
Complications?_____

Mother's health after delivery _____
Post delivery blues ? _____ if yes, how long ? _____

Primary caretaker for child, first year_____
thereafter _____

Feeding history: breast vs bottle _____ age weaned _____ Food allergies _____
Current eating problems _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)
_____
_____

Separations from mother and/or father: age, duration, reaction to _____
_____

Toilet training: age reached bowel control: day _____ night _____ bladder control: day ____ night ___
methods used _____ ease _____ current function _____

Sexual development: gender identity _____
any problems _____

Physical/Sexual Abuse: _____
_____

Name:_____

Motor development: (please write in age, parentheses are approximate normal limits)
rolls over (3-5m) _____ sit without support (5-7m) _____ crawls (5-8) _____
walks well (11-16m) _____ runs well (2y) _____ rides tricycle (3y) _____
throws ball overhand (4y) _____ current level of activity _____
fine and gross motor coordination _____ compared to peers _____

Language development: (please write in age, parentheses are approximate normal limits)
several words besides dada, mama (1y) _____ name several objects-ball, cup (15m) _____
3 words together--subject, verb, object (24m) _____ vocabulary _____ articulation _____
comprehension _____ compared to peers _____
any current problems _____

Social development: (please write in age, parentheses are approximate normal limits)
smile (2m) ____ shy with strangers (6-10m) _____ separates from mother easily (2-3y) _____
cooperative play with others (4y) _____
quality of attachment to mother_____ quality of attachment to father_____
relationships to family members _____
early peer interactions _____
current peer interactions _____
special interests/hobbies _____

Behavioral/Discipline: compliance vs non-compliance _____
lying/stealing _____ rule breaking _____ methods of discipline _____
other problems _____

Emotional development: early temperament _____
current personality _____
mood _____ fears/phobias _____
habits _____
special objects (blankets, dolls, etc.) _____ ability to express of feelings _____

Drug/Alcohol History: _____
_____

School History: current grade _____ school contact _____
number of schools attended _____ average grades _____
homework problems _____
specific learning disabilities _____
strengths _____
what have teachers said about the child/teen _____
_____
Please bring school report cards and any state, national or special testing that has been performed.

Overall Strengths -- as viewed by parents _____
_____

Overall Strengths -- as viewed by the child/teen _____
_____

Name:_____

Child/Teen General Symptom Checklist

Parents please rate your child or teen on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have the child or teen rate him/herself as well. For young children it may not be practical to have them fill out the questionnaire. Use your best judgment and do the best you can.

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Ch/Tn Parent

____ ___ 1. depressed or sad mood
____ ___ 2. not as much interest in things that are usually fun
____ ___ 3. significant recent weight or appetite changes
____ ___ 4. recurrent thoughts of death or suicide
____ ___ 5. sleep changes, lack of sleep or marked increase in sleep
____ ___ 6. low energy or feelings of tiredness
____ ___ 7. feelings of being worthless, helpless, hopeless or guilty
____ ___ 8. plays alone or appears socially withdrawn
____ ___ 9. cries easily
____ ___ 10. negative thinking
____ ___ 11. periods of an elevated, high or irritable mood
____ ___ 12. periods of a very high self esteem or big thinking
____ ___ 13. periods of decreased need for sleep without feeling tired
____ ___ 14. more talkative than usual or feel pressure to keep talking
____ ___ 15. fast thoughts or frequent jumping from one subject to another
____ ___ 16. easily distracted by irrelevant things
____ ___ 17. marked increase in activity level
____ ___ 18. cyclic periods of angry, mean or violent behavior
____ ___ 19. periods of time where you feel intensely anxious or nervous
____ ___ 20. periods of trouble breathing of feeling smothered
____ ___ 21. periods of feeling dizzy, faint or unsteady on your feet
____ ___ 22. periods of heart pounding, fast heart rate or chest pain
____ ___ 23. periods of trembling, shaking or sweating
____ ___ 24. periods of nausea, abdominal upset or choking
____ ___ 25. intense fear of dying
____ ___ 26. lacks confidence in abilities
____ ___ 27. needs lots of reassurance
____ ___ 28. needs to be perfect
____ ___ 29. seems fearful and anxious
____ ___ 30. seems shy or timid
____ ___ 31. easily embarrassed
____ ___ 32. sensitive to criticism
____ ___ 33. bites fingernails or chews clothing
____ ___ 34. persistent refusal to go to school
____ ___ 35. excessive fear of interacting with other children or adults
____ ___ 36. persistent, excessive fear (heights, closed spaces, specific animals, etc.) please list _____
____ ___ 37. excessive anxiety concerning separation from home or from those to whom the child is attached.
____ ___ 38. recurrent bothersome thoughts, ideas or images which you try to ignore
____ ___ 39. trouble getting "stuck" on certain thoughts, or having the same thought over and over
____ ___ 40. excessive or senseless worrying
____ ___ 41. others complain that you worry too much or get "stuck" on the same thoughts
____ ___ 42. compulsive behaviors that you must do or you feel very anxious, such as excessive hand washing, cleaning, checking locks, or counting or spelling
____ ___ 43. needing to have things done a certain way or you become very upset

Name:_____

____ ___ 44. recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.), please list _____
___ ___ 45. recurrent distressing dreams of a past upsetting event
____ ___ 46. feelings of reliving a past upsetting event
____ ___ 47. spend effort avoiding thoughts or feelings related to a past trauma
____ ___ 48. feeling that your future is shortened
____ ___ 49. startle easily
____ ___ 50. feel like you're always watching for bad things to happen
____ ___ 51. refusal to maintain body weight above a level most people consider healthy
____ ___ 52. intense fear of gaining weight or becoming fat even though underweight
____ ___ 53. feelings of being fat, even though you're underweight
____ ___ 54. recurrent episodes of eating large amounts of food
____ ___ 55. a feeling of lack of control over eating behavior
____ ___ 56. engage in activities to eliminate excess food, such as self induced vomiting, laxatives, strict dieting or strenuous exercise
____ ___ 57. persistent worry with body shape and weight
____ ___ 58. involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have motor tics been present?_____ How often?_____ describe_____
____ ___ 59. involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, swearing). How long have verbal tics been present?_____ How often?_____ describe_____
____ ___ 60. repetitive, seemingly driven motor behavior (e.g., hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or bodily orifices, hitting own body) that interferes with normal activities or results in self-inflicted bodily injury that requires medical treatment (or would result in an injury if preventive measures were not used).
____ ____61. passage of feces in inappropriate places (e.g., clothing or floor).
____ ____62. bed wetting. If present, how often?_____
____ ____63. failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.
____ ___ 64. delusional or bizarre thoughts (thoughts you know others would think are false)
____ ___ 65. visual hallucination, seeing objects or images are not really present
____ ___ 66. hearing voices that are not really present
____ ___ 67. odd behaviors
____ ___ 68. poor personal hygiene or grooming
____ ___ 69. inappropriate mood for the situation (i.e., laughing at sad events)
____ ___ 70. frequent feelings that someone or something is out to hurt you
____ ___ 71. problems with social relatedness before the age of 5, either by failing to respond appropriately to others or becoming indiscriminately attached to others
____ ___ 72. multiple changes in caregivers before the age of 5
____ ___ 73. steals
____ ___ 74. bullies, threatens, or intimidates others
____ ___ 75. initiates physical fights
____ ___ 76. cruel to animals
____ ___ 77. force others into things they do not want to do (sexually or criminally)
____ ___ 78. sets fires
____ ___ 79. destroys property
____ ___ 80. break in to others home, school, car or place of business
____ ___ 81. lies
____ ___ 82. stays out at night despite parental prohibitions
____ ___ 83. runs away overnight
____ ___ 84. cuts school
____ ___ 85. doesn't seem sorry for hurting others
____ ___ 86. negative, hostile, or defiant behavior

Name:_____

____ ___ 87. loses temper
____ ___ 88. argues with adults
____ ___ 89. actively defies or refuses to comply with adults' requests or rules
____ ___ 90. deliberately annoys people
____ ___ 91. blames others for his or her mistakes or misbehavior
____ ___ 92. touchy or easily annoyed by others
____ ___ 93. angry and resentful
____ ___ 94. spiteful or vindictive

____ ___ 95. impairment in communication as manifested by at least one of the following:
- delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate
  through alternative modes of communication such as gesture or mime)
- in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- repetitive use of language or odd language
- lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

____ ___ 96. impairment in social interaction, with at least two of the following:
- marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- failure to develop peer relationships appropriate to developmental level
- lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- lack of social or emotional reciprocity

____ ___ 97. repetitive patterns of behavior, interests, and activities, as manifested by at least one of following:
- preoccupation with an area of that is abnormal either in intensity or focus
- rigid adherence to specific, nonfunctional routines or rituals
- repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupation with parts of objects

____ ___ 98. stutters
____ ___ 99. feel tired during the day
____ ___ 100. feel cold when others feel fine or they are warm
____ ___ 101. often feel warm when others feel fine or they are cold
____ ___ 102. problems with brittle or dry hair
____ ___ 103. problems with dry skin
____ ___ 104. problems with sweating
____ ___ 105. problems with chronic anxiety or tension

Name:_____

Child/Teen Amen Brain System Checklist

Please rate your child/teen on each of the symptoms listed below using the following scale. If practical and/or possible, to give us the most complete picture, have the child/teen (Ch/Tn) rate himself or herself. List who filled this out._____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Ch/Tn	Parent		
____	___	1.	Fails to give close attention to details or makes careless mistakes
____	___	2.	Trouble sustaining attention in routine situations (i.e., homework, chores, paperwork)
____	___	3.	Trouble listening
____	___	4.	Fails to finish things
____	___	5.	Poor organization for time or space (such as backpack, room, desk, paperwork)
____	___	6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
____	___	7.	Loses things
____	___	8.	Easily distracted
____	___	9.	Forgetful
____	___	10.	Poor planning skills
____	___	11.	Lack clear goals or forward thinking
____	___	12.	Difficulty expressing feelings
____	___	13.	Difficulty expressing empathy for others
____	___	14.	Excessive daydreaming
____	___	15.	Feeling bored
____	___	16.	Feeling apathetic or unmotivated
____	___	17.	Feeling tired, sluggish or slow moving
____	___	18.	Feeling spacey or "in a fog"
____	___	19.	Fidgety, restless or trouble sitting still
____	___	20.	Difficulty remaining seated in situations where remaining seated is expected
____	___	21.	Runs about or climbs excessively in situations in which it is inappropriate
____	___	22.	Difficulty playing quietly
____	___	23.	"On the go" or acts as if "driven by a motor"
____	___	24.	Talks excessively
____	___	25.	Blurts out answers before questions have been completed
____	___	26.	Difficulty awaiting turn
____	___	27.	Interrupts or intrudes on others (e.g., butts into conversations or games)
____	___	28.	Impulsive (saying or doing things without thinking first)
____	___	29.	Excessive or senseless worrying
____	___	30.	Upset when things do not go your way
____	___	31.	Upset when things are out of place
____	___	32.	Tendency to be oppositional or argumentative
____	___	33.	Tendency to have repetitive negative thoughts
____	___	34.	Tendency toward compulsive behaviors
____	___	35.	Intense dislike for change
____	___	36.	Tendency to hold grudges
____	___	37.	Trouble shifting attention from subject to subject
____	___	38.	Trouble shifting behavior from task to task
____	___	39.	Difficulties seeing options in situations
____	___	40.	Tendency to hold on to own opinion and not listen to others
____	___	41.	Tendency to get locked into a course of action, whether or not it is good
____	___	42.	Needing to have things done a certain way or you become very upset
____	___	43.	Others complain that you worry too much
____	___	44.	Tend to say no without first thinking about question

Name:_____

____ ___45. Tendency to predict fear
____ ___46. Frequent feelings of sadness
____ ___47. Moodiness
____ ___48. Negativity
____ ___49. Low energy
____ ___50. Irritability
____ ___51. Decreased interest in others
____ ___52. Decreased interest in things that are usually fun or pleasurable
____ ___53. Feelings of hopelessness about the future
____ ___54. Feelings of helplessness or powerlessness
____ ___55. Feeling dissatisfied or bored
____ ___56. Excessive guilt
____ ___57. Suicidal feelings
____ ___58. Crying spells
____ ___59. Lowered interest in things usually considered fun
____ ___60. Sleep changes (too much or too little)
____ ___61. Appetite changes (too much or too little)
____ ___62. Chronic low self-esteem
____ ___63. Negative sensitivity to smells/odors
____ ___64. Frequent feelings of nervousness or anxiety
____ ___65. Panic attacks
____ ___66. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)
____ ___67. Periods of heart pounding, rapid heart rate or chest pain
____ ___68. Periods of trouble breathing or feeling smothered
____ ___69. Periods of feeling dizzy, faint or unsteady on your feet
____ ___70. Periods of nausea or abdominal upset
____ ___71. Periods of sweating, hot or cold flashes
____ ___72. Tendency to predict the worst
____ ___73. Fear of dying or doing something crazy
____ ___74. Avoid places for fear of having an anxiety attack
____ ___75. Conflict avoidance
____ ___76. Excessive fear of being judged or scrutinized by others
____ ___77. Persistent phobias
____ ___78. Low motivation
____ ___79. Excessive motivation
____ ___80. Tics (motor or vocal)
____ ___81. Poor handwriting
____ ___82. Quick startle
____ ___83. Tendency to freeze in anxiety provoking situations
____ ___84. Lacks confidence in their abilities
____ ___85. Seems shy or timid
____ ___86. Easily embarrassed
____ ___87. Sensitive to criticism
____ ___88. Bites fingernails or picks skin
____ ___89. Short fuse or periods of extreme irritability
____ ___90. Periods of rage with little provocation
____ ___91. Often misinterprets comments as negative when they are not
____ ___92. Irritability tends to build, then explodes, then recedes, often tired after a rage
____ ___93. Periods of spaciness or confusion
____ ___94. Periods of panic and/or fear for no specific reason
____ ___95. Visual or auditory changes, such as seeing shadows or hearing muffled sounds
____ ___96. Frequent periods of deja vu (feelings of being somewhere you have never been)
____ ___97. Sensitivity or mild paranoia
____ ___98. Headaches or abdominal pain of uncertain origin

Name:_____

____ ___99. History of a head injury or family history of violence or explosiveness
____ ___100. Dark thoughts, may involve suicidal or homicidal thoughts
____ ___101. Periods of forgetfulness or memory problems

Name:_____

Mother's Amen Brain System Checklist

This form should be filled out by the *biological or adopted mother on herself*, if possible. If it is not possible please have it filled out by someone who knows her well. Please rate yourself on each of the symptoms listed below using the following scale. If possible have the father or other person who knows the biological mother rate her as well. List who filled this out._____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other	Mother		
____	___	1.	Fails to give close attention to details or makes careless mistakes
____	___	2.	Trouble sustaining attention in routine situations (i.e., homework, chores, paperwork)
____	___	3.	Trouble listening
____	___	4.	Fails to finish things
____	___	5.	Poor organization for time or space (such as backpack, room, desk, paperwork)
____	___	6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
____	___	7.	Loses things
____	___	8.	Easily distracted
____	___	9.	Forgetful
____	___	10.	Poor planning skills
____	___	11.	Lack clear goals or forward thinking
____	___	12.	Difficulty expressing feelings
____	___	13.	Difficulty expressing empathy for others
____	___	14.	Excessive daydreaming
____	___	15.	Feeling bored
____	___	16.	Feeling apathetic or unmotivated
____	___	17.	Feeling tired, sluggish or slow moving
____	___	18.	Feeling spacey or "in a fog"
____	___	19.	Fidgety, restless or trouble sitting still
____	___	20.	Difficulty remaining seated in situations where remaining seated is expected
____	___	21.	Runs about or climbs excessively in situations in which it is inappropriate
____	___	22.	Difficulty playing quietly
____	___	23.	"On the go" or acts as if "driven by a motor"
____	___	24.	Talks excessively
____	___	25.	Blurts out answers before questions have been completed
____	___	26.	Difficulty waiting turn
____	___	27.	Interrupts or intrudes on others (e.g., butts into conversations or games)
____	___	28.	Impulsive (saying or doing things without thinking first)
____	___	29.	Excessive or senseless worrying
____	___	30.	Upset when things do not go your way
____	___	31.	Upset when things are out of place
____	___	32.	Tendency to be oppositional or argumentative
____	___	33.	Tendency to have repetitive negative thoughts
____	___	34.	Tendency toward compulsive behaviors
____	___	35.	Intense dislike for change
____	___	36.	Tendency to hold grudges
____	___	37.	Trouble shifting attention from subject to subject
____	___	38.	Trouble shifting behavior from task to task
____	___	39.	Difficulties seeing options in situations
____	___	40.	Tendency to hold on to own opinion and not listen to others
____	___	41.	Tendency to get locked into a course of action, whether or not it is good
____	___	42.	Needing to have things done a certain way or you become very upset

Name:_____

____ ___43. Others complain that you worry too much
____ ___44. Tend to say no without first thinking about question
____ ___45. Tendency to predict fear
____ ___46. Frequent feelings of sadness
____ ___47. Moodiness
____ ___48. Negativity
____ ___49. Low energy
____ ___50. Irritability
____ ___51. Decreased interest in others
____ ___52. Decreased interest in things that are usually fun or pleasurable
____ ___53. Feelings of hopelessness about the future
____ ___54. Feelings of helplessness or powerlessness
____ ___55. Feeling dissatisfied or bored
____ ___56. Excessive guilt
____ ___57. Suicidal feelings
____ ___58. Crying spells
____ ___59. Lowered interest in things usually considered fun
____ ___60. Sleep changes (too much or too little)
____ ___61. Appetite changes (too much or too little)
____ ___62. Chronic low self-esteem
____ ___63. Negative sensitivity to smells/odors
____ ___64. Frequent feelings of nervousness or anxiety
____ ___65. Panic attacks
____ ___66. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)
____ ___67. Periods of heart pounding, rapid heart rate or chest pain
____ ___68. Periods of trouble breathing or feeling smothered
____ ___69. Periods of feeling dizzy, faint or unsteady on your feet
____ ___70. Periods of nausea or abdominal upset
____ ___71. Periods of sweating, hot or cold flashes
____ ___72. Tendency to predict the worst
____ ___73. Fear of dying or doing something crazy
____ ___74. Avoid places for fear of having an anxiety attack
____ ___75. Conflict avoidance
____ ___76. Excessive fear of being judged or scrutinized by others
____ ___77. Persistent phobias
____ ___78. Low motivation
____ ___79. Excessive motivation
____ ___80. Tics (motor or vocal)
____ ___81. Poor handwriting
____ ___82. Quick startle
____ ___83. Tendency to freeze in anxiety provoking situations
____ ___84. Lacks confidence in their abilities
____ ___85. Seems shy or timid
____ ___86. Easily embarrassed
____ ___87. Sensitive to criticism
____ ___88. Bites fingernails or picks skin
____ ___89. Short fuse or periods of extreme irritability
____ ___90. Periods of rage with little provocation
____ ___91. Often misinterprets comments as negative when they are not
____ ___92. Irritability tends to build, then explodes, then recedes, often tired after a rage
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____ ___96. Frequent periods of deja vu (feelings of being somewhere you have never been)

Name:_____

____ ___97. Sensitivity or mild paranoia
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____ ___99. History of a head injury or family history of violence or explosiveness
____ ___100. Dark thoughts, may involve suicidal or homicidal thoughts
____ ___101. Periods of forgetfulness or memory problems

Name:_____

Father's Amen Brain System Checklist

This form should be filled out by the *biological or adopted father on himself*, if possible. If it is not possible please have it filled out by someone who knows him well. Please rate yourself on each of the symptoms listed below using the following scale. If possible have the mother or other person who knows the biological father rate him as well. List who filled this out._____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other	Father		
____	___	1.	Fails to give close attention to details or makes careless mistakes
____	___	2.	Trouble sustaining attention in routine situations (i.e., homework, chores, paperwork)
____	___	3.	Trouble listening
____	___	4.	Fails to finish things
____	___	5.	Poor organization for time or space (such as backpack, room, desk, paperwork)
____	___	6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
____	___	7.	Loses things
____	___	8.	Easily distracted
____	___	9.	Forgetful
____	___	10.	Poor planning skills
____	___	11.	Lack clear goals or forward thinking
____	___	12.	Difficulty expressing feelings
____	___	13.	Difficulty expressing empathy for others
____	___	14.	Excessive daydreaming
____	___	15.	Feeling bored
____	___	16.	Feeling apathetic or unmotivated
____	___	17.	Feeling tired, sluggish or slow moving
____	___	18.	Feeling spacey or "in a fog"
____	___	19.	Fidgety, restless or trouble sitting still
____	___	20.	Difficulty remaining seated in situations where remaining seated is expected
____	___	21.	Runs about or climbs excessively in situations in which it is inappropriate
____	___	22.	Difficulty playing quietly
____	___	23.	"On the go" or acts as if "driven by a motor"
____	___	24.	Talks excessively
____	___	25.	Blurts out answers before questions have been completed
____	___	26.	Difficulty awaiting turn
____	___	27.	Interrupts or intrudes on others (e.g., butts into conversations or games)
____	___	28.	Impulsive (saying or doing things without thinking first)
____	___	29.	Excessive or senseless worrying
____	___	30.	Upset when things do not go your way
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____	___	38.	Trouble shifting behavior from task to task
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____	___	41.	Tendency to get locked into a course of action, whether or not it is good
____	___	42.	Needing to have things done a certain way or you become very upset

Name:_____

____ ___43. Others complain that you worry too much
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____ ___46. Frequent feelings of sadness
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____ ___101. Periods of forgetfulness or memory problems

Name:_____

Childhood Depression Inventory

Name: _____

Date: _____

INSTRUCTIONS:

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups of three statements. From each group pick one sentence that describes you best for the past two weeks. After you pick a sentence from the first group, then go on to the next group of three statements.

There is no right or wrong answer. Just pick the sentence that best describes the way you have been feeling recently. Put a mark like this **X** next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example how this form works. Try it, put a mark next to the sentence that describes you best.

EXAMPLE:

- ☐ I read books all the time.
- ☐ I read books once in a while.
- ☐ I never read books.

Remember, pick out the sentences that describe your feelings and thoughts in the past two weeks.

1. ☐ I am sad once in a while.
   ☐ I am sad many times.
   ☐ I am sad all the time.

2. ☐ Nothing will ever work out for me.
   ☐ I am not sure if things will work out for me.
   ☐ Things will work out for me O.K.

3. ☐ I do most things O.K.
   ☐ I do many things wrong.
   ☐ I do everything wrong.

4. ☐ I have fun in many things.
   ☐ I have fun in some things.
   ☐ Nothing is fun at all.

5. ☐ I am bad all the time.
   ☐ I am bad many times.
   ☐ I am bad once in a while.

Name:_____

6. ☐ I think about bad things happening to me once in a while.
☐ I worry that bad things will happen to me.
☐ I am sure that terrible things will happen to me.

7. ☐ I hate myself.
☐ I do not like myself.
☐ I like myself.

8. ☐ All bad things are my fault.
☐ Many bad things are my fault.
☐ Bad things are not usually my fault.

9. ☐ I do not think about killing myself.
☐ I think about killing myself but would not do it.
☐ I want to kill myself.

10. ☐ I feel like crying everyday.
☐ I feel like crying many days.
☐ I feel like crying once in a while.

11. ☐ Things bother me all the time.
☐ Things bother me many times.
☐ Things bother me once in a while.

12. ☐ I like being with people.
☐ I do not like being with people many times.
☐ I do not want to be with people at all.

13. ☐ I can not make up my mind about things.
☐ It is hard to make up my mind about things.
☐ I make my mind about things easily.

14. ☐ I look O.K.
☐ There are some bad things about my looks.
☐ I look ugly.

15. ☐ I have to push myself all the time to do my schoolwork.
☐ I have to push myself many times to do my schoolwork.
☐ Doing schoolwork is not a big problem.

16. ☐ I have trouble sleeping every night.
☐ I have trouble sleeping many nights.
☐ I sleep pretty well.

17. ☐ I am tired once in a while.
☐ I am tired many days.
☐ I am tired all the time.

Name:_____

18. ☐ Most days I do not feel like eating.
☐ Many days I do not feel like eating.
☐ I eat pretty well.

19. ☐ I do not worry about aches and pains.
☐ I worry about aches and pains many times.
☐ I worry about aches and pains all the time.

20. ☐ I do not feel alone.
☐ I feel alone many times.
☐ I feel alone all the time.

21. ☐ I never have fun at school.
☐ I have fun at school only once in a while.
☐ I have fun at school many times.

22. ☐ I have plenty of friends.
☐ I have some friends but I wish I had more.
☐ I do not have any friends.

23. ☐ My school work is alright.
☐ My school work is not as good as before.
☐ I do very poorly in subjects I used to be good in.

24. ☐ I can never be as good as other kids.
☐ I can be as good as other kids if I want to.
☐ I am just as good as other kids.

25. ☐ Nobody really loves me.
☐ I am not sure if anybody loves me.
☐ I am sure that somebody loves me.

26. ☐ I usually do what I am told.
☐ I do not do what I am told most times.
☐ I never do what I am told.

27. ☐ I get along with people.
☐ I get into fights many times.
☐ I get into fights all the time.

NOTICE OF PRIVACY PRACTICES
Mental Health Solutions, LLC

BOISE LOCATION: 3152 S Bown Way Suite 6 MERIDIAN LOCATION: 2596 N Stokesberry Pl. Suite 135
Phone: 208-371-8040 Fax: 866-371-6410
IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Satu Woodland PMHCNS NP 208-371-8040

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTIFICATION IS CONSISTENT WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RULE. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable use to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

TABLE OF CONTENTS

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We have a written contract with these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information, which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under Oregon law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. If you belong to a Managed Health Care Plan we may also share medical information about you to all the other health care providers in said plan, who participate in the plan for any health care operations activities related to the plan.
4. Appointment Reminders (If applicable). We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone or send via email.
5. Waiting room. We may also call out your name when we are ready to see you.
6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or other person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with family and others.
7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information for marketing purposes without your written authorization.
8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and Oregon law.
11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
14. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
15. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
16. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
17. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board of privacy board, in compliance with governing law.

18. Please note: Communication: Please do not communicate personal health information to me via email or text message. Either call me on the phone and/or download PingMd app on your phone which is HIPAA secure. Any other form is not HIPAA secure.

19. Workers' Compensation: Our practice may disclose your health information as necessary to comply with workers' compensation and similar programs.
20. Office Location: If you are concerned for privacy at any of our locations (e.g. you know a worker in that building, etc.) you may ask to make appointments at a particular time or at another of our locations.
BOISE LOCATION: 3152 S Bown Way Suite 6 MERIDIAN LOCATION: 2596 N. Stokesberry Pl. Suite 135

B. When This Medical Practice May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights
1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Oregon law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 through 16 Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to Paper Copy. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

D. Changes to this Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our office area, and will have available to you a copy at each appointment. We will also post the current notice on our website, if and when one is developed.

E. Complaints
Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be done in writing and directed to our Practice Manager.
Mailing Address:
Mental Health Solutions
3060 S Rookery Lane
Boise , ID 83706
Or Fax to 866-371-6410
If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:
Department of Health and Human Services
Office for Civil Rights
Hubert H. Humphrey Blvd.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201
You will not be penalized for filing a complaint.

To be completed during session

Satu H. Woodland PMHCNS

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral health (BH) care providers and your primary care physician (PCP), and other behavioral health providers and/or facilities, is important to ensure you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the individual(s) or entities named below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires in 1 year from the date of my signature below unless otherwise stated herein.

Satu H Woodland, PMHCNS, is authorized to release protected health information related to the evaluation and

treatment of _____ _____/_____/_____ to:
(Patient name) (Date of birth – MM/DD/YYYY)

PCP name: _____ PCP phone: _____

PCP address: _____ _____
(Street) (City) (State) (ZIP code)

BH provider name: _____ BH provider phone: _____

BH provider address: _____ _____
(Street) (City) (State) (ZIP code)

Other name: _____ Other phone: _____

Other address: _____ _____
(Street) (City) (State) (Zip code)

Disclosure may include the following verbal or written information: (check all that apply)

___ Face sheet	___ History and physical	___ Laboratory/diagnostic testing results	___ School information
___ Discharge summary	___ Medication records	___ Behavioral health/psychological consult	___ Psychological evaluation/testing results
___ ER record report	___ Psychiatric evaluation	___ Psychosocial assessment	___ Other
___ Substance abuse treatment record		___ Summary of treatment records and contact dates	

___ I hereby refuse to give authorization for any release of information until specified otherwise.

_____ _____
(Signature of patient, parent, guardian or authorized representative) (Date)

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e., power of attorney, living will, guardianship papers, etc.)