Cynthia Palman, M.D.
3003 Willamette Street
Eugene, Oregon

Patient's Name ______________________________ Date of Birth ________________

Welcome to my practice. I look forward to working with you. In order to provide the best care possible, I have chosen to be in solo practice. This means you will be talking to me about most aspects of your care. I do work with someone on the insurance aspect of things and questions will likely be best answered by her. Please review the policies I outline below and sign at the bottom.

Office Policies

Appointments: appointment times are set aside specifically for you. Keeping appointments is an essential part of excellent treatment. Please give at least 24 hours' notice if you cannot keep my appointment, with 48 hours' notice for Monday appointments. A missed appointment or one cancelled less than 24 hours prior may be charged the full session fee.

Prescriptions: Prescriptions for medications are given at the time of appointments. In general they will be for sufficient medication to last till the next scheduled appointment. You may run out of medication if you miss my appointments. If you do need a refill prior to your appointment please contact my pharmacy regular business hours Monday thru Friday. Controlled medications require a written script that has to be picked up by arrangement. Please will give at least 3 days notice of the need for controlled medication refills.

Emergency Coverage: Due to the individualized nature of her practice, Dr. Palman provides her own coverage. She will make every attempt to return your call within a reasonable time period. If you feel you are experiencing an emergency and Dr. Palman is not available, you may wish to call your primary care physician, White Bird Crisis Counseling at 541 687-4000, or go directly to the Emergency Department.

Discharge from care: Failure to follow these policies may result in my discharge from care.

If you do not have insurance: I require payment in full at the time of your appointment unless you have made other arrangements with me. I work with you on a discount for self-pay clients.

If you do have insurance: I participate as a preferred or "in network" provider with several insurance companies. Most other insurances will allow out of network providers usually with an increased rate of coinsurance on your part. Copays are required at the time of service. I do not send out statements, so I ask you to be aware of your balance. I need a copy of a valid insurance card and photo ID to be able to submit claims for you.

Financial Responsibility: If your insurance denies the claim or is not valid, you are responsible for the bill. Parents or guardians of adolescents are responsible for providing them with the copay prior to the appointment. If your account remains unpaid, I can discontinue services and send your account to a collection agency.

I have read this agreement carefully before signing.

_____________________________________ ________________
Signature of Patient Date

___________________________________ _________________________________
Signature of Insured/Guarantor/Authorized Representative (If different from above) Signature of Legal Guardian

Assignment of Insurance Benefits/Release of Medical Information

I authorize Dr. Palman to release any medical information which may be requested to process claims for payment of medical services through an insurance carrier or medical agency.

I request that payment be made to Cynthia Palman M.D. for any bills for service rendered to me by my doctor.

I understand that I am financially responsible to my doctor for any balance not covered by this authorization. I understand that insurance filing is done as a courtesy for the patient and my doctor takes no responsibility for denial or delay of payment.

___

Responsible party's signature | printed name of signee | patient name if different | date

Informed Consent for Treatment

I give my consent for services for myself or my child/legal dependent with Cynthia Palman M.D. to include evaluation, psychotherapy, and/or medication management. I may at any time decline specific recommendations. I understand that medical treatment, including psychotherapy, has inherent risks that may include but not be limited to side effects or worsening of symptoms. I may withdraw this consent at any time.

___

Responsible party's signature | printed name of signee | patient name if different | date

Consent to Release Information to Primary Care Physician

Communication between health providers and your primary care physician is important to help ensure you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, updates and medication. You can discuss specific information to be released with Dr. Palman.

I, do___/do not____ authorize Dr. Palman to release information related to my evaluation and treatment plan to:

Primary Care Physician:____ Phone________________________________

Address

___

street | city | state | zip

___

Responsible party's signature | printed name of signee | patient name if different | date

If you would information released to another physician please request a separate release of information form.

ADULT INTAKE INFORMATION – page 1
(To be completed by client)

Client's Name: ____Today's Date____________________________

Partner's Name (if being seen as a couple): ____

Address: ____City, State, Zip: ___________________________

Home phone: ____________________________ Work phone:______________________ Partner's phone: __________

Social Security (ID) Number: Self: ________________________________ Partner (optional): ___________________

May we leave messages for you at home? ☐ Yes ☐ No May we leave messages for you at work? ☐ Yes ☐ No

Gender: ☐ M ☐ F Age: _______________ Birth Date:_______________________ Marital Status:_____________

Others Living in Home (name, birth date, relationship to client): ______________________________________

Education: Self: ____Partner: ______________________________

Occupation: Self: ____Partner: ______________________________

Client's Employer: ____

Emergency Contact: ____Phone: _______________________________

Referred by: ____

INSURANCE INFORMATION

Name of Insured: ____Insured Date of Birth:___________________

Address of Insured:____City, State, Zip: ______________________

Relationship of Client to Insured: _____________________________Employer of Insured:___________________

Insurance Company:____Phone: _____________________________

Insurance Company Address: __________________________________City, State, Zip:_______________________

Insurance Identification Number: ______________________________Group Number: ______________________

Secondary insurance: ____Phone: ____________________________

Name of Secondary Insured: ___________________________________Insured Date of Birth:__________________

Secondary Company Address: __________________________________City, State, Zip:______________________

Secondary Identification Number: ______________________________Group Number: _____________________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services. I understand that I am financially responsible for any balance not covered by insurance.

Signature____ Date_______________

ADULT INTAKE INFORMATION – page 2

(To be completed by client)

MEDICAL HISTORY

How do you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Had any major injuries or accidents? (please circle)

Yes No

Major illnesses? (please circle)

Yes No

Are you currently experiencing any chronic pain? (please circle)

Yes No

How do you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How many times per week do you exercise? ____

Name of your Primary Care Physician:

Phone: _______________________ Address: ____

Date of your most recent physical exam: _____________________________________

List all medications you are currently taking & the dosage of each, if known:

____
____
____

Mental Health History:

Are you currently experiencing any of the following? (please circle)

Overwhelming sadness, grief or depression Yes No

Anxiety, panic attacks or have any phobias? Yes No

Eating problems? Yes No

Sexual problems? Yes No

Hyperactivity or uncontrollable energy? Yes No

Difficulty paying attention or concentrating? Yes No

Have you or anyone in your family ever received counseling? ___Yes ____No

Has anyone in your family ever received medication or been hospitalized for mental health reasons? ____ Yes ____ No

ADULT INTAKE INFORMATION – page 3

(To be completed by client)

Has anyone in the family threatened or attempted suicide? _____Yes ____ No

Has your or a family member's drug or alcohol use caused problems in the family?

_____Yes _____ No

If yes please explain____

Primary substance

Age of first use

Number of days since last use

Frequency of use or degree of impairment

Additional Information:

Do you enjoy your work? Is there anything stressful about your current work?
____
____
____

What is your ethnic/cultural background and spiritual or religious background?
____
____
____

What do you consider to be some of your strengths?
____
____
____

What do you consider to be some of your weaknesses?
____
____
____

What would you like to accomplish out of your time in therapy? (the reason you are seeking services):
____
____
____
____
____

Cynthia Palman, MD
NOTICE OF PRIVACY PRACTICES

This notice describes how clinical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY

Who will follow this notice

This notice describes the privacy practices followed by Cynthia Palma, as the Practitioner, and by office personnel.

Your health information

This notice applies to the information and records I have about your health, status, and the health services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, diagnoses, treatments, procedures, and similar types of health-related information.

I am required by law to give you this notice. It will tell you about the ways in which I may use and disclose protected health information (PHI) about you and describes your rights and my obligations regarding the use and disclosure of that information.

How I may use and disclose health information about you without your authorization:

- **For Treatment.** I may use health information about you to provide you with clinical treatment or services. I may disclose health information about you to other health care providers who are involved in your treatment. For example, information may be shared to create and carry out a plan for your treatment.
- **For Payment**. I may use and disclose health information about you to get payment or to pay for the services you receive. For example, I may need to give your health plan information about a service you received here so your health plan will pay me or reimburse you for the service. I may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for treatment.
- **For Health Care Operations.** I may use and disclose health information about you in order to run the office and make sure that you and my other clients receive quality care. For example, I may use your health information to evaluate the performance of my staff in caring for you or to help us decide what additional services I should offer.
- **Required By Law and for Law Enforcement.** I will disclose health information about you when required to do so by federal, state or local law or in response to a court order.
- **To Avert a Serious Threat to Health or Safety.** I may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others.

For Drug and Alcohol Program Issues: Federal and State law require your written consent each time I release health information. The Consent will specify who is to receive the information, the purpose of the release of information, and a time period after which the Consent will terminate. You may change

or cancel a Consent at any time. However, if I am unable to fulfill my requirements related to treatment, payment or health care operations, I may choose to discontinue providing you with health care treatment and services

In some instances, I may need specific, written authorization from you in order to disclose information such as HIV, substance abuse, and mental health information

Uses and disclosures in special situations

I may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations. Please notify me if you do not wish to be contacted for appointment reminders, or if you would not like to receive information about other treatment or health services. If you advise me **verbally or in writing** that you do not wish to receive such communications, I will not use or disclose your information for these purposes.

- **Appointment Reminders.** I may contact you as a reminder that you have an appointment for treatment at my office.
- **Alternative Treatment or Health Services.** I may tell you about other possible treatment options or health-related products or services that may be of interest to you.
- **Research.** I may use and disclose health information about you for research projects that are subject to a special approval process. I will ask you for your written permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Information Not Personally Identifiable.** I may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, I may be required by military command or other government authorities to release health information about you. I may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** I may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. This is not relevant for clients with drug or alcohol issues.
- **Public Health Risks.** I may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** I may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Family and Friends.** I may disclose health information about you to your family members or friends if you so choose. For example, I may assume you agree to my disclosure of your personal health information to your spouse when you bring your spouse with you into the treatment room during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to

your incapacity or medical emergency), I may, using my professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only health information relevant to the person's involvement in your care. For example, I may inform the person who accompanied you to the emergency room of your health status.

Other uses and disclosures require your written authorization

I will not use or disclose your health information for any purpose other than those listed above without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may cancel that *Authorization*, **in writing**, at any time. If you cancel your *Authorization*, I will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but I cannot take back any uses or disclosures made before your cancelled the *Authorization*.

Your privacy rights

- **Right to Inspect and Copy.** In many cases, you have the right to look at and copy your health information, such as clinical records that I keep.
  You must submit a written request to my Privacy Officer/Contact Person, in order to look at and/or copy records. I may charge a fee for the costs of copying, mailing or supplies.
  I may deny your request to inspect and/or copy in certain limited circumstances. If you are denied copies of or access to health information that I keep about you, you may ask that my denial be reviewed. If the law gives you a right to have my denial reviewed, I will select a licensed health care professional to review your request and my denial. The person conducting the review will not be the person who denied your request, and I will comply with the outcome of the review.
- **Right to Amend.** If you believe health information I have about you is incorrect or incomplete, you may ask me to correct or update the information. You have the right to request this change as long as the information is kept by this office.
  To request an amendment, complete and submit a "Clinical Record Amendment/Correction Form" to my Privacy Officer/Contact Person.
  I may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. If your request is denied, I will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. In addition, I may deny your request if you ask me to amend information that:
  - I did not create, unless the person or agency that created the information is no longer available to make the change
  - Is not part of the health information that I keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete

- **Right to a List of Disclosures.** You have the right to request a list, or an "accounting" of disclosures. This is a list of the disclosures I made of clinical information about you for purposes other than treatment, payment, health care operations, and the special circumstances involving national security, correctional institutions and law enforcement listed above. The list will not include the disclosures that were made with your written authorization.
  To obtain this list, you must submit your request **in writing** to my Privacy Officer/Contact Person. It must state a time period, which may not be longer than seven years and may not include

dates before April 14, 2003. Your request should indicate how you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, I may charge you for the costs of providing the list. I will notify you of the cost involved and you can decide if you want the list or not.

- **Right to Request Restrictions.** You have the right to request a limitation on the health information I use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information I disclose about you. For example, you could ask that I not use or disclose specific information to a particular party.

  I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you may complete and submit the "Request for Restriction on Use/Disclosure of Clinical Information" to my Privacy Officer/Contact Person.
- **Right to Request Confidential Communications.** You have the right to choose how I communicate with you. For example, you can ask that I only contact you at work or by mail.

  To request confidential communications, you may complete and submit the "Request for Restriction on Use/Disclosure of Clinical Information" and/or "Request for Confidential Communications" to my Privacy Officer/Contact Person. You do not have to explain the reason for your request. I will accommodate all reasonable requests. Your request should state how you would like to be contacted by me.
- **Right to a Paper Copy of This Notice.** You will be given a copy of this notice. If you have not received a copy of it, you may ask us for one at any time.

  To obtain such a copy, contact my Privacy Officer/Contact Person.

Changes to this notice

Changes may be made to this notice. I will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

Complaints

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