THE INCREDIBLE YEARS

WHAT IS THE GROUP?

The Incredible Years is a treatment program for parents, teachers and children ages 4-6. Supported by decades of research, it is designed to address disruptive behavior, hyperactivity, impulsivity, emotion dysregulation, anger and poor peer interactions. Parents and children meet in separate sessions, running simultaneously for 9 weeks. There is then an option to continue for another 9 week module.

The child treatment component is called Dinosaur School. It uses the Dina Dinosaur Social Emotional Skills and Problem-solving Curriculum. This curriculum is part of the broader Incredible Years series specifically created for children and parents of children with behavioral problems. The children attend the Dinosaur School while parents meet to learn skills for supporting their child. Children will have the opportunity to learn new skills through role-play, videos, modeling, group discussion and live practice. The group setting is designed to be fun and positive with a token system in place to motivate children and reinforce desirable behavior. Children come away from the group with enhanced awareness and knowledge of their emotions, and strategies for how to handle frustrations and cope with upsets and steps for solving problems and reducing conflict. Children learn feelings detection and expression, problem-solving, anger control, self-regulation, social skills and cooperation.

The parenting program is designed to strengthen parenting skills and prevent and treat behavior problems in young children. Parents learn relationship building, behavior management, de-escalation and child skill development. Sessions focus on strengthening parent-child interactions and attachment; providing parents with positive discipline tools that really work. Parents learn to promote children's social, emotional and language development. Parents view video clips of real-life situational vignettes to support the training and trigger group discussions, as well as hands-on problem solving and practice exercises.

The program includes 9 sessions for parents and 9 sessions for children. The cost of the program is $900. Both parent and child sessions may be billable to health insurance. An initial consultation (billable to insurance) is required. Eligible families will be given a specialized packet to complete and return prior to the first visit. Group size is limited. Childcare will be available for siblings of group participants (see Frequently Asked Questions).

The program is led by Drs. Rose Eagle and Nichole Sage.

FREQUENTLY ASKED QUESTIONS
THE INCREDIBLE YEARS GROUP

How is the group set? Families meet with one of the group leaders for an initial consultation ($150) and determine if the group is a fit for your child/family's need. The group then meets weekly for 9 weeks (please see the calendar). Group sessions are 75 minutes. The parent group and the children's group run simultaneously.

What is the cost of the group? Both group sessions are billed in 75 minute blocks and may be insurance reimbursable. Parent sessions ($50/visit) are billed under the adult's name. Child sessions ($50/visit) are billed under the child's name. A separate copay/coinsurance is collected for each adult and child session. For families for whom we are billing insurance a deposit will be collected upon registration. Copays/coinsurance will be applied to this deposit. Unless you are paying in full we require a credit card number on file with your registration.

What if we miss one? The program is considered a "package" service. There is no credit for group sessions or parent meetings that are missed and CANNOT be billed to your health insurance.

What if I decide the group is not for my child? For weekly group attendees, if you decide the group program is not right for your child before the third session you will not be charged for any additional sessions. Once a family has begun the third session, they have made a commitment to the program and will be billed for all subsequent sessions/meetings. In a rare circumstance we may agree that it is not in the child's best interest to continue. If that is the case you will not be charged for the balance of sessions.

Do you bill insurance? Our office is contracted to bill certain insurance companies. Please refer to the Financial Information sheet for a list of the insurance companies we currently bill or contact the billing office at (503) 452-0307. Remember, billing insurance is not a guarantee of payment. Sessions missed for any reason cannot be billed to insurance and the fee for that session ($50) is owed. We require a credit card on file with you your registration. Any balance owing will be charged to the credit card on file at the end of the group. Some insurance companies will ask for written information regarding you or your child. Although we will not be writing reports, we will provide the carrier with a description of the group, the dates of the sessions, and your/your child's diagnosis.

My insurance requires pre-authorization. Will you call them or fill out the necessary paperwork? Not without an appointment. If your insurance company requires pre-authorization and they are unwilling to pre-certify with the information already provided to you, you may schedule an appointment to complete the treatment planning. At that time, the authorization will be requested via phone or letter. These appointments are scheduled for 45 minutes at the treatment-planning rate of $150.00.

Can we talk at the end of a session? The ending of the group session is a hectic time. If you need to share information please arrange a short phone call or email. Please remember <u>extended</u> phone/email contact is not part of the group and will be billed to you directly. This is not insurance reimbursable. Please leave any paperwork at the front desk.

Where do we wait? Wait for class to begin in the office waiting room on the 3rd floor. Please arrive promptly so the groups will not be disrupted by students entering late. Please remember there are people working nearby.

What about bad weather? In case of inclement weather, please call the office (503) 452-8002 to check if group will be held. We request an email address for each family so we can communicate information in this way as well.

Is childcare available? Childcare will be available for siblings of participants in the group. Sign-up is required. The cost will be $5 per child and parents are asked to pay the babysitters directly at the end of each group.

Dear Parents of Incredible Years Group:

We are excited to have gotten things started! Here are some important details that we want you to know.

Please arrive promptly so that the groups will not be disrupted by late arrivals. Additionally, we have a lot to cover for each group.

Please refer to the group calendar for dates/times of group meetings.

ALL FAMILIES ARE ASKED TO PROVIDE AN EMAIL ADDRESS for contact purposes

Please leave all messages, notes, paperwork, etc. with the front desk.

Only parents/legal guardians will be allowed to participate unless additional permission is obtained. Everything that goes on in group is strictly confidential. We ask that families not discuss the details of other children or families in the group.

Occasionally, we have students in training and clinicians attend or observe a group session. Visitors would never be given information about your children. If you have additional questions or concerns regarding this, please speak with a group leader.

Many families wish to talk with us at the end of the group. Please try to keep things short or arrange some time through reception to talk by phone. Extended phone calls are not part of the group and will be billed to you directly. These are not insurance reimbursable.

You should have already received forms that need to be completed and returned so you/your child can participate in the group program.

Please follow the steps on the Financial Information form. A deposit is required to register prior to the group starting. Families not paying in full for the group program MUST PROVIDE A CREDIT CARD NUMBER in order to register their child. This card will be charged for any remaining balance (after insurance) at the conclusion of the group.

Although we bill by session we consider the group a "package" service. Sessions not attended cannot be made-up nor billed to health insurance.

Although this rarely has happened, it is possible you or we will decide that the group is not appropriate for your child. If this happens before the third child session, there will be no additional charges. Once a family has begun the third session, they have made a commitment to the program and will be billed for all subsequent sessions unless we agree that is not to the parent/child's benefit to continue.

Childcare will be available for siblings of participants in the group. Sign-up is required. The cost will be $5 per child and parents are asked to pay the babysitters directly at the end of each group.

I have read and understand the above information and consent to participate in the Incredible Years Group. **Please sign and return a copy of this letter with your packet**

_____	_____
Rose Eagle, Ph.D. Licensed Psychologist	Parent Name
	_____
	Parent Signature
	_____
	Child's Name
_____	_____
Nichole Sage, Psy.D. Licensed Psychologist	Date

The Incredible Years Group Registration Form

Child's Name: _____ DOB:_____

Address: _____

_____

Parent / Guardian Name: _____

Phone Numbers: Day _____ Cell _____ Evening: _____

E-mail _____

Has your child been seen at this clinic before? ☐ Yes ☐ No

If yes, for: ☐ evaluation ☐ therapy

Desired Group Name _____

Dates/Times _____

Will you be using childcare? ☐ Yes ☐ No How many children? _____ Cost $5/per child

Please read the Financial Policy for Groups and call the office to determine if we bill your health insurance. Send this registration form with a photocopy of your insurance card, the Information and Consent for Payment and Healthcare Operations forms, and your deposit. A CREDIT CARD NUMBER MUST ACCOMPANY ALL REGISTRATIONS NOT PAID IN FULL. Balances owed 90 days after insurance has paid will be charged to this credit card. If you must cancel, please notify us within 4 business days prior to the start of the group so we can refund your registration fee. Cancellations received after that time will receive a refund, less a $35 administrative fee. We reserve the right to refund your registration by check. Your refund will be mailed to you within approximately four weeks.

Insurance Company: _____

Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Employer: _____ Phone: _____

☐ **Check (please mail)** ☐ **Mastercard** ☐ **Visa** ☐ **Discover** ☐ **AMX** ☐ **PayPal**

(Provide credit card information below)

Cardholder's Name: _____

Card Number: _____ **Exp. Date:** _____

Security Code: _____

Return this form by mail or fax to Children's Program.

6443 SW Beaverton-Hillsdale Hwy, Suite 300, Portland, OR 97212

(503) 452-0084 (fax) **info@childrensprogram.com**

CHILD DEVELOPMENT QUESTIONNAIRE

Person completing form_____Relationship_____ Date _____

1. Child's full name _____ ☐M ☐F
   Age_____ Birthdate_______________ Grade_____ Child lives with: _____

2. Parent #1 _____ Age_____ Occupation_____
   ☐ Married ☐ Divorced ☐ Other _____
   Address (if different)_____
   (street/P.O. Box) (city) (state) (zip)

   Email Address _____
   Phone (Home)_____(Cell)_____ (Work) _____

   Parent #2 _____ Age_____
   Occupation_____
   ☐ Married ☐ Divorced ☐ Other _____
   Address (if different)_____
   (street/P.O. Box) (city) (state) (zip)
   Email Address _____
   Phone (Home)_____(Cell) _____ (Work) _____

3. Step-parent/significant other_____ Step-parent/significant other_____
   Age_____ Occupation_____ Age _____ Occupation _____

4. Children in the family, first-born to last, gender, age: Other people living in the home and their relationship
   1._____ 1._____
   2._____ 2._____
   3._____ 3._____

5. Has this child lived with persons other than parents? (If yes, please describe):
   _____

6. Has this child experienced (please give dates): Family Moves _____ Marital separation _____
   Divorce_____ Remarriage_____ Other _____

7. Who referred you to the Children's Program? _____

8. Have you received services from our clinic before? ☐ YES ☐ NO (If yes, please describe)
   _____

9. What brings you here today: _____
   _____

10. What questions would you like addressed by our evaluation/consultation for your child? _____

_____

_____

11. Are you or is anyone in your immediate family struggling with issues you would like to discuss?

_____

12. Are you interested in a referral for yourself or a family member regarding any of these concerns?

_____

_____

13. Has anyone in your family had problems similar to your child's problems? ☐ Yes ☐ No (If yes, please describe):

14. Is there a family history of: (including extended family)

☐ psychiatric illness	☐ mental retardation/developmental disorders
☐ inherited medical condition	☐ emotional/behavioral disorders
☐ learning/language disability	☐ ADD/ADHD (attention problems, hyperactivity)
☐ drugs or alcohol use/abuse	☐ autism/spectrum disorders

15. Have you consulted with other agencies, clinics, or professionals about these concerns? ☐ Yes ☐ No
(If yes, please describe):_____

_____

16. Other problems? (If yes, please describe, including name(s) and treatment date(s)): ☐ Yes ☐ No

_____

_____

17. Has the child been affected by issues such as witnessing violence, having accidents, experiencing loss or abuse (physical, sexual, emotional)? ☐ Yes ☐ No

18. Please list your child's strengths/special talents and weaknesses as they relate to family:

Strengths	Weaknesses
1. _____	1. _____
2. _____	2. _____

19. Do your concerns about your child affect your marriage/relationships? Explain: _____

_____

20. Additional information that would assist us in understanding your child:

_____

_____

MEDICAL INFORMATION/HISTORY: Child's physician(s)_____Phone_____

Has your child seen a doctor within the last year? (If yes, please explain why): ☐ Yes ☐ No _____

_____

Were there problems/concerns with: ☐ pregnancy ☐ labor & delivery? ☐ during the newborn period?

Has your child experienced:

☐ serious illnesses	☐ chronic ear infections	☐ injury or trauma to the head
☐ surgeries	☐ allergies	☐ medical conditions we should be aware of
☐ seizures	☐ hospitalizations	

Are there concerns past/present about:
☐ diet/eating ☐ bowel/bladder control
☐ sleep ☐ drug/alcohol use

Has your child taken medication for behavior or psychiatric problems? Currently? ☐ Yes ☐ No
Past? ☐ Yes ☐ No

EDUCATIONAL HISTORY:

1. Current School District _____ School _____ Grade _____

   Teacher _____ Phone #: _____

   School staff person you would like us to contact regarding your child?
   _____ Position: _____

2. Has your child repeated any grades? Which grades? _____ For what reasons?

   _____

3. Please list each grade in which your child experienced significant difficulty or success and explain:

Grade	Location	Explanation
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. List any special educational or remedial services your child is currently receiving or has received in the past:

   _____
   _____

5. Please describe any current problems at school:

   _____
   _____

6. Have you spoken to the child's teacher or school counselor? ☐ YES ☐ NO (If yes, please describe)

   _____
   _____

7. Please describe any evaluation(s) done by the school and your understanding of the results:

   _____
   _____

8. Do you have concerns re: ☐ grades ☐ school performance ☐ relationships with teachers
   ☐ relationships with friends or peers in school

9. Anything else you would like to let us know?_____

   _____

PLEASE ATTACH COPIES OR BRING IN RELEVANT SCHOOL INFORMATION, REPORT CARDS, ETC.

----------For Office Use Only----------

This information has been reviewed and considered in evaluation and treatment planning.

Clinician's Signature _____ Date _____

Clinician's Signature _____ Date _____

TREATMENT CONSENT

WELCOME TO THE CHILDREN'S PROGRAM! We look forward to assisting you with your goals. Here is some important information you should know BEFORE we begin to work with you/your child(ren)/family.

STAFF AND OUR SERVICES: The Children's Program is a private, multidisciplinary clinic. Our clinical staff consists of a licensed developmental/behavioral pediatrician, consulting psychiatrists, licensed psychologists, licensed professional counselors, and certified educational specialists. We help adults, families and children with social, emotional, developmental, and learning concerns. When you call for an initial appointment we encourage you to formulate questions for us to answer or specific goals you want to accomplish. With that information we will schedule appointments for consultation, evaluation and/or treatment with appropriate staff.

During the first appointment, your clinician will introduce him/herself to you and, at your request, share specifics regarding his/her education and training. You can then further clarify goals and agree how they will be reached. If you have difficulty describing clear goals for treatment, it is important to discuss this with your clinician. We will work with you to meet your/your family's specific needs. It is a collaborative process that is provided without a guarantee of satisfaction or results. You retain the right to request changes in treatment or to end treatment at any time. When medication is recommended, your doctor will discuss the risks, benefits, and alternatives. When accepting a prescription for medication, you agree to follow the prescribing physician's recommendations regarding ALL aspects of treatment. If we recommend referral inside the clinic, information will be shared between clinicians. If we recommend referral outside our clinic, we will attempt to provide you with alternatives.

IF YOU ARE RECEIVING SERVICES UNDER A MANAGED CARE HEALTH INSURANCE CONTRACT, your policy may limit behavioral health coverage to **"medically necessary" procedures (for acute symptom relief)**. It is the responsibility of the patient/ family to ensure all necessary preauthorization is current. Your provider has an agreement with your insurance company to provide services within the limitations of these conditions. The managed care company may require a release of information about your treatment to the primary care physician. Your managed care health insurance company hires reviewers to assess the record keeping and functioning of provider offices. As part of this process, they may either send a reviewer to our office to inspect your record or request a copy of your record be sent to their office for review. If this is the case, we will follow all procedures to protect the confidentiality of your record. Your managed care insurance may request that information regarding treatment and/or treatment authorization be transmitted via facsimile or e-mail. If you do not want us to send or receive information in this manner on your behalf please inform your clinician and specify this request in writing. Some concerns you want to address in therapy may not meet the conditions of your insurance coverage. Should you want to receive treatment for a non-covered condition, your therapist will discuss options with you.

The Children's Program will not be a party to any legal proceedings/lawsuits. Our goal is to support clients to achieve therapy goals, not to address legal issues. Clients entering treatment agree not to involve the Children's Program and their treating clinician in legal/court proceedings or attempts to obtain records of treatment/evaluation for use in legal/court proceedings.

CONFIDENTIALITY: The privacy of your evaluation/treatment is important to us. Information shared with clinicians is confidential. The Children's Program maintains a single chart to record the services that are provided. We will maintain your chart for 7 years from the last date of treatment. Information from that record can be shared with other professionals/agencies/individuals **ONLY** with your **WRITTEN** consent by signing a release to disclose confidential information. Please be conservative and circumspect when requesting release of information. This is to protect your child/family's privacy now and into the future as your child ages. Please be aware that the record we release may be released by other providers/agencies. The Release to Disclose Confidential Information form requires specifying **WHAT** information is to be shared, **WHO** shall receive it, for **WHAT** purpose and the **DATES** of the confidential information. In Oregon, the age of consent for treatment and release of mental health records is 14 years of age. The signature of patients 14 years or older is required to release the information in the treatment record. With written permission, we can communicate with other professionals on your behalf via phone or email and provide evaluation reports and/or a summary of treatment. We do not generally release patient chart notes or test protocols. If under a special circumstance, release of additional information is requested, this will be reviewed after conferring with the patient/family members and the requesting clinician/physician. There may be charges for photocopying and mailing records. In the case of divorce, both parents have equal access to the information in the chart of a child under the age of 14. If consultation with other professionals on your behalf is necessary, your anonymity will be preserved.

We may, but do not guarantee calls to remind you of upcoming appointments. Please let us know **EACH** time you schedule an appointment if you **DO NOT** want a reminder call.

We respect the rights of a child/parent/adult to have particular information remain private between themselves and the therapist. If you have concerns about this, let your therapist know and a comfortable arrangement can be reached which allows therapy to progress, yet respects the rights of individuals. Please advise us in writing if you wish to be contacted only in a particular way or only at particular phone numbers. There are several situations in which the law requires clinicians to make exceptions to the confidentiality of communications between client and clinician. These situations are:

- when there is suspected child, elder, or disabled abuse
- when there is threat of harm to self or others
- when medically relevant information is needed for emergency medical treatment
- when records are subpoenaed by order of a Judge, or if the client waives confidentiality
- when conducted at the request of an outside agency with the client's approval

(please see reverse side)

information may be required by your insurance company to process a claim. Typically, this involves disclosure of a diagnosis and the dates of services, though at times, more may be required. Your file may be reviewed for quality assurance by the Children's Program or your insurance company. We will maintain your confidentiality during this process.

ELECTRONIC COMMUNICATION, I.E., E-MAIL/FAX, PRESENTS A POTENTIAL RISK TO PATIENT CONFIDENTIALITY. Email is not a replacement for office visits. While families and patients may find this a convenient way to communicate they must be aware of the risks and discuss them with their clinician. If a patient/family still wishes to assume these risks and communicate with their clinician in this way, they may acknowledge this by signing below and exchanging information with their clinician within a session. Clinically relevant information exchanged by fax/email may become a part of the clinical record.

FEES/PAYMENT: Fees are billed on an hourly basis and vary for each discipline. When you call for an appointment, we provide an estimate of the fee(s). We will inform you if this changes. We request payment of the fee(s) at each appointment. In some cases, we will bill your primary insurance directly. HOWEVER, THIS DOES NOT GUARANTEE COVERAGE. Health insurance plans vary widely in their mental health coverage. A copy of our **FINANCIAL POLICY** is available on our website. **Please read our Financial Policy**. We require that you read/sign **INFORMATION** and **CONSENT FOR PAYMENT** forms prior to initiating evaluation/treatment**.** We require you provide a valid credit card number. Charges remaining after 90 days may be charged if you have not called us regarding arrangements for payment of a past due balance

There are circumstances that impose additional fees. To cancel a scheduled therapy or consultation appointment, please call during office hours and give at least 24 business hours' advance notice. A mandatory fee of up to 100% of the charge will be assessed for missed appointments or appointments cancelled without sufficient notice. Cancellations left on voicemail after business hours will be considered received as of the next business day. Reminder phone calls are not guaranteed. If you must cancel an evaluation appointment, please notify us at least one week in advance. We may elect not to reschedule evaluations cancelled without sufficient notice. You will be charged for telephone/email consultation outside a session or a cancellation without sufficient notice. This is billed at the clinician's hourly rate and is not reimbursable by a health insurance company. Same day requests for refills of prescriptions incur a $10 charge. If a clinician is required to testify on a client's behalf court preparation/travel/testimony will be billed at $200 per hour. In the unlikely event that your account is referred to a collection agency or small claims court, we will release your name, address, phone number, social security number, and amount owed. You will be notified in writing if this is to occur.

EMERGENCIES: Office phones are answered between 8:00 a.m. and Noon and 1:00-5:15 p.m. Monday through Thursdays and between 8:00 a.m. – Noon and 1:00-3:30 p.m. on Fridays. The office is closed on Fridays during July and August. Messages may be left on the voicemail at any time. Our clinicians will attempt to return your call within 24 hours. If you feel you have an **emergency** situation that cannot wait until the office re-opens, please call the Answering Service at (503) 294-1309. They will make every effort to contact your clinician; however, it is possible that your clinician may be unavailable or unreachable. Families needing immediate attention are advised to contact the Emergency Room of the nearest hospital.

GRIEVANCE PROCEDURE: If you have concerns regarding these policies, please discuss them with your clinician during your initial session. Should you feel dissatisfied with your treatment for any reason, please talk to your clinician. If you and your clinician are unable to resolve the problems, you may submit a written letter of concern to our Clinic Administrator. You will receive notice of action taken within 10 working days.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND I CONSENT TO TREATMENT. BY FURNISHING MY EMAIL ADDRESS, I CONSENT TO THE USE OF EMAIL TO COMMUNICATE.

Email Address: _____

_____ _____
(Name of Patient) (Date of Birth)

_____ _____
Signature (clients age 14 years and above) (Date)

_____ _____
Signature (Parent/Guardian/Legal Rep.) (Relationship to Client) (Date)
(If Guardian/Legal representative, please provide documentation of guardianship status.)

_____ _____
Clinician's Signature (Date)

Please sign and return this form.

6443 SW Beaverton Hillsdale Hwy, Suite 320, Portland, OR 97221
(503) 452-8002 Fax: (503) 452-0084
www.childrensprogram.com

ADULT INFORMATION FORM

Today's Date _____

Client's Name _____

DOB _____ Gender: ☐ Male ☐ Female Marital Status _____

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

DOB _____ Gender: ☐ Male ☐ Female Marital Status: _____

Address _____ _____ _____ _____
(Street) (City) (State) (Zip)

Telephone _____ _____ _____
(home) (cell) (work)

May we leave messages for you at home? ☐ YES ☐ NO At work? ☐ YES ☐ NO

Education: Self_____ Partner _____

Occupation: Self _____ Partner _____

Client's Employer _____

Emergency Contact _____ Phone _____

PRESENTING PROBLEMS

Describe the problem that brought you here today:

_____

_____

_____

_____

_____

Check any of the symptoms you are having:

Depression	☐	Feeling Hopeless	☐
Extreme Sadness	☐	Feeling Tearful	☐
Trouble Concentrating	☐	Change in Sleeping Habits	☐
Memory Problems	☐	Lack of Energy	☐
Change in Eating Habits	☐	Weight Changes	☐
Feelings of Extreme Happiness	☐	Change in Sexual Interest/Function	☐
Trouble Performing Your Job	☐	Feeling Stressed	☐
Not Enjoying Usual Activities	☐	Problems Getting Along With Others	☐
Self-Esteem Problems	☐	Easily Irritated	☐
Perfectionism	☐	Feeling Guilty	☐
Obsessions or Compulsions	☐	Feeling Nervous	☐
Feeling Fearful	☐	Sudden Feelings of Panic	☐
Physical Complaints of Pain	☐	Muscle Tension	☐
Problems With Anger	☐	Acting Violently	☐
Thoughts of Hurting or Killing Self	☐	Thoughts of Hurting or Killing Others	☐

Comments:

_____

_____

_____

_____

WHAT IS YOUR HISTORY WITH PRESENTING PROBLEM?

HAVE YOU EVER BEEN IN COUNSELING BEFORE? ☐ YES ☐ NO

If you have been in counseling before, please describe it below starting with the most recent.

1. Name of Counselor _____
   Dates Seen _____
   Explain What Happened _____
   _____
   _____

2. Name of Counselor _____

Dates Seen _____

Explain What Happened _____

_____

_____

MEDICAL INFORMATION

Have you seen a doctor within the past year? ☐ YES ☐ NO

If yes, what was the reason? _____

_____

_____

Who is your doctor? _____ Phone: _____

Are you taking any kind of medicine (prescription or over-the-counter)? ☐ YES ☐ NO

Please list any medicines you are taking: _____

_____

_____

Do you have allergies to anything? ☐ YES ☐ NO

Please describe any allergy problems you may have: _____

_____

SUBSTANCE USE HISTORY

Do you use/have you used tobacco (any form)?	☐ Currently	☐ Past	☐ Never
Do you use/have you used alcohol?	☐ Currently	☐ Past	☐ Never
Do you use/have you used caffeine (any form)?	☐ Currently	☐ Past	☐ Never
Do you use/have you used recreational drugs?	☐ Currently	☐ Past	☐ Never

SUICIDAL BEHAVIOR/THOUGHTS/self harm:

FAMILY HISTORY AND RELATIONSHIPS:

SOCIAL SUPPORTS. Please describe the nature of your friendships/social supports? Are you involved in any meaningful activities? Community supports and self help groups?

VOCATION/EMPLOYMENT:

TRAUMA HISTORY?

LIFE GOALS/Strengths and barriers at achieving goals? Past success at achieving goals?

What are your goals for therapy?

CONSENT FOR HEALTHCARE OPERATIONS

CLIENT_____**DOB:**_____

I understand I am financially responsible for all charges. Payment is due in full on the day of service. If the Children's Program agrees to bill insurance, I will pay co-payments, co-insurance or deductibles as required at each visit. I understand billing insurance is not a guarantee of payment. If my insurance denies coverage for services or procedures, I am responsible for the charges. Accounts must be paid in full within 90 days. Balances remaining after 60 days will accrue billing charges. Charges remaining after 90 days will be charged to the credit card on file to avoid further billing or collection fees.

- I request health insurance payments be made directly to Children's Program. If the insurance carrier sends payment to the patient/family member, I will forward payment to the Children's Program for credit to my account. **The Children's Program may disclose the information necessary to process my insurance claims to any person, corporation, or agency responsible for payment including: _____insurance carrier _____school _____other (specify)**

- I acknowledge that the patient does not hold Oregon Health Plan Insurance (OHP). If the patient unknowingly has OHP insurance, as either primary or secondary insurance, I waive the right to have OHP billed.

- In cases of divorce, the parent/guardian initiating service is responsible for the account and must sign this form. If that parent does not carry the client's health insurance, this form must also be signed by the individual who carries the insurance in order to submit a claim and have the benefits assigned to our office.

- I understand that I must call **DURING OFFICE HOURS** and give at least **24 business hours advance notice** when canceling an appointment. If I fail to do so, I understand I will be charged up to the full appointment fee.

- If I am receiving services under a managed care mental health insurance contract, I understand I may be required to obtain preauthorization before scheduling appointments. The health insurance carrier may limit the number of appointments I can schedule, or the time period in which appointments may occur. My health insurance may limit the types of procedures or diagnoses for which treatment is provided. I agree to be financially responsible for appointments that are not covered by health insurance because of breech of any of these conditions.

- If I choose to submit claims for services outside Children's Program insurance billing policies, I am aware that Children's Program will not accept assignment/provider discounts.

- I understand I must notify the Children's Program of any changes in my health insurance coverage prior to the next appointment. I understand the Children's Program will not retroactively bill for changes if insurance carrier.

- In the event of nonpayment of charges, the Children's Program shall be entitled to disclose information and recover all costs and expenses incurred in seeking collection of such charges including, without limitations, court costs and reasonable attorney's fees, whether such claims are pursued through court proceedings, appellate or bankruptcy proceedings, arbitration, or mediation.

Patient care coordination standards strongly recommend the practice of sharing information with the patient's PEDIATRICIAN. I consent to the Children's Program exchanging information as appropriate.

_____

Name of Pediatrician **Group Affiliation if Applicable**

_____

Office Address

I have read and authorized the above.

_____

Financially Responsible Party/Legal Guardian Date Relationship to client

TREATMENT CONSENT

WELCOME TO THE CHILDREN'S PROGRAM! We look forward to assisting you with your goals. Here is some important information you should know BEFORE we begin to work with you/your child(ren)/family.

STAFF AND OUR SERVICES: The Children's Program is a private, multidisciplinary clinic. Our clinical staff consists of a licensed developmental/behavioral pediatrician, consulting psychiatrists, licensed psychologists, licensed professional counselors, and certified educational specialists. We help adults, families and children with social, emotional, developmental, and learning concerns. When you call for an initial appointment we encourage you to formulate questions for us to answer or specific goals you want to accomplish. With that information we will schedule appointments for consultation, evaluation and/or treatment with appropriate staff.

During the first appointment, your clinician will introduce him/herself to you and, at your request, share specifics regarding his/her education and training. You can then further clarify goals and agree how they will be reached. If you have difficulty describing clear goals for treatment, it is important to discuss this with your clinician. We will work with you to meet your/your family's specific needs. It is a collaborative process that is provided without a guarantee of satisfaction or results. You retain the right to request changes in treatment or to end treatment at any time. When medication is recommended, your doctor will discuss the risks, benefits, and alternatives. When accepting a prescription for medication, you agree to follow the prescribing physician's recommendations regarding ALL aspects of treatment. If we recommend referral inside the clinic, information will be shared between clinicians. If we recommend referral outside our clinic, we will attempt to provide you with alternatives.

IF YOU ARE RECEIVING SERVICES UNDER A MANAGED CARE HEALTH INSURANCE CONTRACT, your policy may limit behavioral health coverage to **"medically necessary" procedures (for acute symptom relief)**. It is the responsibility of the patient/ family to ensure all necessary preauthorization is current. Your provider has an agreement with your insurance company to provide services within the limitations of these conditions. The managed care company may require a release of information about your treatment to the primary care physician. Your managed care health insurance company hires reviewers to assess the record keeping and functioning of provider offices. As part of this process, they may either send a reviewer to our office to inspect your record or request a copy of your record be sent to their office for review. If this is the case, we will follow all procedures to protect the confidentiality of your record. Your managed care insurance may request that information regarding treatment and/or treatment authorization be transmitted via facsimile or e-mail. If you do not want us to send or receive information in this manner on your behalf please inform your clinician and specify this request in writing. Some concerns you want to address in therapy may not meet the conditions of your insurance coverage. Should you want to receive treatment for a non-covered condition, your therapist will discuss options with you.

The Children's Program will not be a party to any legal proceedings/lawsuits. Our goal is to support clients to achieve therapy goals, not to address legal issues. Clients entering treatment agree not to involve the Children's Program and their treating clinician in legal/court proceedings or attempts to obtain records of treatment/evaluation for use in legal/court proceedings.

CONFIDENTIALITY: The privacy of your evaluation/treatment is important to us. Information shared with clinicians is confidential. The Children's Program maintains a single chart to record the services that are provided. We will maintain your chart for 7 years from the last date of treatment. Information from that record can be shared with other professionals/agencies/individuals **ONLY** with your **WRITTEN** consent by signing a release to disclose confidential information. Please be conservative and circumspect when requesting release of information. This is to protect your child/family's privacy now and into the future as your child ages. Please be aware that the record we release may be released by other providers/agencies. The Release to Disclose Confidential Information form requires specifying **WHAT** information is to be shared, **WHO** shall receive it, for **WHAT** purpose and the **DATES** of the confidential information. In Oregon, the age of consent for treatment and release of mental health records is 14 years of age. The signature of patients 14 years or older is required to release the information in the treatment record. With written permission, we can communicate with other professionals on your behalf via phone or email and provide evaluation reports and/or a summary of treatment. We do not generally release patient chart notes or test protocols. If under a special circumstance, release of additional information is requested, this will be reviewed after conferring with the patient/family members and the requesting clinician/physician. There may be charges for photocopying and mailing records. In the case of divorce, both parents have equal access to the information in the chart of a child under the age of 14. If consultation with other professionals on your behalf is necessary, your anonymity will be preserved.

We may, but do not guarantee calls to remind you of upcoming appointments. Please let us know **EACH** time you schedule an appointment if you **DO NOT** want a reminder call.

We respect the rights of a child/parent/adult to have particular information remain private between themselves and the therapist. If you have concerns about this, let your therapist know and a comfortable arrangement can be reached which allows therapy to progress, yet respects the rights of individuals. Please advise us in writing if you wish to be contacted only in a particular way or only at particular phone numbers. There are several situations in which the law requires clinicians to make exceptions to the confidentiality of communications between client and clinician. These situations are:

- when there is suspected child, elder, or disabled abuse
- when there is threat of harm to self or others
- when medically relevant information is needed for emergency medical treatment
- when records are subpoenaed by order of a Judge, or if the client waives confidentiality
- when conducted at the request of an outside agency with the client's approval

(please see reverse side)

information may be required by your insurance company to process a claim. Typically, this involves disclosure of a diagnosis and the dates of services, though at times, more may be required. Your file may be reviewed for quality assurance by the Children's Program or your insurance company. We will maintain your confidentiality during this process.

ELECTRONIC COMMUNICATION, I.E., E-MAIL/FAX, PRESENTS A POTENTIAL RISK TO PATIENT CONFIDENTIALITY. Email is not a replacement for office visits. While families and patients may find this a convenient way to communicate they must be aware of the risks and discuss them with their clinician. If a patient/family still wishes to assume these risks and communicate with their clinician in this way, they may acknowledge this by signing below and exchanging information with their clinician within a session. Clinically relevant information exchanged by fax/email may become a part of the clinical record.

FEES/PAYMENT: Fees are billed on an hourly basis and vary for each discipline. When you call for an appointment, we provide an estimate of the fee(s). We will inform you if this changes. We request payment of the fee(s) at each appointment. In some cases, we will bill your primary insurance directly. HOWEVER, THIS DOES NOT GUARANTEE COVERAGE. Health insurance plans vary widely in their mental health coverage. A copy of our **FINANCIAL POLICY** is available on our website. **Please read our Financial Policy**. We require that you read/sign **INFORMATION** and **CONSENT FOR PAYMENT** forms prior to initiating evaluation/treatment**.** We require you provide a valid credit card number. Charges remaining after 90 days may be charged if you have not called us regarding arrangements for payment of a past due balance

There are circumstances that impose additional fees. To cancel a scheduled therapy or consultation appointment, please call during office hours and give at least 24 business hours' advance notice. A mandatory fee of up to 100% of the charge will be assessed for missed appointments or appointments cancelled without sufficient notice. Cancellations left on voicemail after business hours will be considered received as of the next business day. Reminder phone calls are not guaranteed. If you must cancel an evaluation appointment, please notify us at least one week in advance. We may elect not to reschedule evaluations cancelled without sufficient notice. You will be charged for telephone/email consultation outside a session or a cancellation without sufficient notice. This is billed at the clinician's hourly rate and is not reimbursable by a health insurance company. Same day requests for refills of prescriptions incur a $10 charge. If a clinician is required to testify on a client's behalf court preparation/travel/testimony will be billed at $200 per hour. In the unlikely event that your account is referred to a collection agency or small claims court, we will release your name, address, phone number, social security number, and amount owed. You will be notified in writing if this is to occur.

EMERGENCIES: Office phones are answered between 8:00 a.m. and Noon and 1:00-5:15 p.m. Monday through Thursdays and between 8:00 a.m. – Noon and 1:00-3:30 p.m. on Fridays. The office is closed on Fridays during July and August. Messages may be left on the voicemail at any time. Our clinicians will attempt to return your call within 24 hours. If you feel you have an **emergency** situation that cannot wait until the office re-opens, please call the Answering Service at (503) 294-1309. They will make every effort to contact your clinician; however, it is possible that your clinician may be unavailable or unreachable. Families needing immediate attention are advised to contact the Emergency Room of the nearest hospital.

GRIEVANCE PROCEDURE: If you have concerns regarding these policies, please discuss them with your clinician during your initial session. Should you feel dissatisfied with your treatment for any reason, please talk to your clinician. If you and your clinician are unable to resolve the problems, you may submit a written letter of concern to our Clinic Administrator. You will receive notice of action taken within 10 working days.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND I CONSENT TO TREATMENT. BY FURNISHING MY EMAIL ADDRESS, I CONSENT TO THE USE OF EMAIL TO COMMUNICATE.

Email Address: _____

_____ _____
(Name of Patient) (Date of Birth)

_____ _____
Signature (clients age 14 years and above) (Date)

_____ _____
Signature (Parent/Guardian/Legal Rep.) (Relationship to Client) (Date)
(If Guardian/Legal representative, please provide documentation of guardianship status.)

_____ _____
Clinician's Signature (Date)

Please sign and return this form.

6443 SW Beaverton Hillsdale Hwy, Suite 320, Portland, OR 97221
(503) 452-8002 Fax: (503) 452-0084
www.childrensprogram.com

Financial Policy for the Incredible Years Group

1) For this group, both you (a parent) and your child are the clients. Billing is submitted under each name. Please let us know if you and your child have different health insurance.

2) Our office maintains a direct billing relationship with many, but not all, health insurance companies**.** We bill the companies listed below:

- Aetna (most plans)
- Blue Cross products (unless managed by a third party)
- HMA
- Lifewise
- Managed Healthcare Northwest
- MODA
- PacificSource (Managed Healthcare NW Network , Preferred PSN)
- Providence Health Plans
- Regence Blue Cross of Oregon, Teamsters BC, Federal BC, BC/BS of varying states using the PPO network.
- United HealthCare/United Behavioral Health
- UMR
- First Choice Network Plans

3) It is important for families to educate themselves about the mental health benefits of their health insurance policies. Please call your insurance company PRIOR to the beginning of any group to determine your coverage. Inquire if your company provides a managed mental health benefit, whether you must meet a deductible, the amount of your co-payment/coinsurance, and whether pre-authorization is required. In most cases pre-authorization is initiated by the family/patient and NOT the primary care physician/pediatrician. Coverage **may exclude** specific diagnoses e.g., Attention Deficit, Autism Spectrum, or a specific service such as group therapy.

4) **Therapy groups are a package.** There is no credit for missed parent meetings or group therapy sessions. Please note: missed group sessions cannot be billed to your health insurance and the fee for that session is then owed by the family. The agreement with your insurance carrier is a contract between you, your insurance company and, in some cases, your employer. Please remember, billing insurance is not a guarantee of payment.

5) If we are billing your primary health insurance please complete the following:

- ✓ A Registration form for the attending adult **AND** the child.
- ✓ An Information form for the adult **AND** the child.
- ✓ A Consent for Payment and Healthcare Operations form for the adult **AND** child.
- ✓ A photocopy of your health insurance card.

Registrations must include the required deposit **AND** Credit Card Information. Incomplete registrations will not be accepted. If you must cancel, please notify us within 4 business days prior to the start of the group so we can refund your registration fee. Cancellations received after that time will receive a refund, less a $35 administrative fee. We reserve the right to refund your registration by check. Your refund will be mailed to you within approximately four weeks.

Our policy is to bill a patient's primary insurance carrier and allow 60 days for the claim to be paid. If a payment has not been received from an insurance company within 60 days, we encourage the patient to contact their insurance company. Please review the Explanation of Benefits your insurance company provides. Accounts unpaid after 60 days are your responsibility.

6) Some insurance companies will ask for written information regarding the group. Although we will not be writing reports, we will provide the carrier with a description of the group, the dates of the sessions, and you/your child's diagnosis. Additional treatment planning will require a treatment session with Dr. Eagle or Dr. Sage.

7) If we are NOT contracted to bill your health insurance, **payment in full** is due at the time of registration. Families using an out-of-network benefit should contact their insurance carrier **prior** to beginning a group. Verify your mental health benefits and whether pre-authorization or treatment planning is required. If an insurance company requires completion of paperwork in order for you to receive reimbursement, you must schedule an appointment with the clinician running the group prior to the first group session. This appointment is billed at a rate of $150 for a 50-minute session. Please contact our Accounts Manager to obtain copies of the materials you will need to send a claim to your insurance company along with a guide for self-billing insurance. This information is available after the group has ended.

8) Financial arrangements between divorced parents must be handled independent of the Children's Program. In cases of divorce, the parent seeking service is responsible for the account and must sign the Consent for Payment and Healthcare Operations form. If the other parent holds the insurance, they, too, must sign the Consent for Payment and Healthcare Operations form. This gives us permission to bill the health insurance.

9) Payment can be made with a check, cash, MasterCard, Visa, Discover, American Express, PayPal, or with an HSA, HRA or Benefits credit card. Please call our Billing Office if you need a printout of your account or to answer any questions.

10) Accounts with unpaid balances after 90 days must be paid to avoid collection action. We will make every attempt to contact you to settle the balance and reserve the right to use the credit card number on file to settle the balance.

11) In the event of non-payment of charges, the Children's Program shall be entitled to recover all costs and expenses incurred in seeking collection of such charges, including, without limitation, court costs and reasonable attorney's fees, whether such claims are pursued through court proceedings, appellate or bankruptcy proceedings, arbitration, and/or mediation.

The Incredible Years Child Treatment Group Curriculum

Dina Dinosaur Social Emotional Skills and Problem-Solving Curriculum

The Dina Dinosaur Social Emotional Skills and Problem-Solving Curriculum or Dinosaur School is a research-based program created to improve emotion regulation, conflict management, cooperation and social skills in young children. This curriculum is part of the broader Incredible Years series, which was specifically created for children and parents of children with behavioral problems. The children will attend the Dinosaur School group while parents meet to learn skills for supporting their child. They will have the opportunity to learn new skills through role-play, videos, modeling, group discussion and live practice. The group setting is designed to be fun and positive, with a token system in place to motivate children and reinforce desirable behavior. Children come away from the group with an enhanced awareness and knowledge of their emotions, strategies for how to handle frustrations and cope with upsets, and steps for solving problems and reducing conflict.

Session 1 Apatosaurus Unit: Making Friends and Learning School Rules

Session 2 Triceratops Unit: Understanding and Detecting Feelings Part 1

Session 3 Triceratops Unit: Understanding and Detecting Feelings Part 2

Session 4 Iguanadon Unit: Learning to Problem-Solve Part 1

Session 5 Iguanadon Unit: Learning to Problem-Solve Part 2

Session 6 Stegosaurus Unit: Anger Management Part 1

Session 7 Stegosaurus Unit: Anger Management Part 2

Session 8 Stegosaurus Unit: Anger Management Part 3

Session 9 Integrating and Reviewing Skills

The Incredible Years Basic Preschool Parenting Program Curriculum

The Incredible Years Parenting Program is designed to strengthen parenting skills and prevent and treat behavior problems in young children. We will focus on strengthening parent-child interactions and attachment, providing parents with positive discipline tools that really work and also fostering the parents' ability to promote children's social, emotional and language development. This group uses video clips of real-life situational vignettes to support the training and trigger parenting group discussions, as well as hands-on problem solving and practice exercises.

Session 1 Introduction/Child Directed Play

Session 2 Praise and Encouragement

Session 3 Incentives

Session 4 Rules and Routines

Session 5 Effective Limit Setting

Session 6 Follow Through with Commands

Session 7 Ignoring

Session 8 Time Out to Calm Down

Session 9 Natural Consequences/Wrap-Up

THE INCREDIBLE YEARS
REGISTRATION CHECKLIST

Did You:

1. Complete the **Registration** forms (one for the attending adult and one for the child). **Payment in full or a $350 deposit PLUS credit card information (if we are billing insurance), must accompany the registration.**

2. Remember to put all the meetings on your calendar!

3. Enclose a photocopy of the front and back of your insurance card if your health insurance is on the list of companies we bill. This is essential if you would like us to bill the insurance for you. Also, please provide a copy of the photo ID of the guarantor of the account.

4. Please read, sign, and return the following forms:

   a. 2 Treatment Consent Form (one for the adult and one for the child)
   b. 2 Consent for Healthcare Operations (one for the adult and one for the child)
   c. 1 Dear Parent Letter (sign and return one and keep one for your records)
   d. A Child Development Questionnaire and an Adult Questionnaire (unless we have one on file).

5. Your credit card numbers MUST be included for your registration to be processed unless you are paying in full.

Keep this packet handy while your child is attending the group program. You may want to refer to it in the future.

Children's Program
(503) 452-8002

THE INCREDIBLE YEARS -New Session

WINTER/SPRING 2017 CALENDAR

(All balances not billed to insurance and insurance deductibles must be paid before the first parent meeting or a payment arrangement verified)

Tuesday	3/14/17	Group Meeting	4:00-5:15 p.m.
Tuesday	3/21/17	Group Meeting	4:00-5:15 p.m.
Tuesday	3/28/17	NO GROUP	SPRING BREAK
Tuesday	4/4/17	Group Meeting	4:00-5:15 p.m.
Tuesday	4/11/17	Group Meeting	4:00-5:15 p.m.
Tuesday	4/18/17	Group Meeting	4:00-5:15 p.m.
Tuesday	4/25/17	Group Meeting	4:00-5:15 p.m.
Tuesday	5/2/17	Group Meeting	4:00-5:15 p.m.
Tuesday	5/9/17	Group Meeting	4:00-5:15 p.m.
Tuesday	5/16/17	Group Meeting	4:00-5:15 p.m.
Tuesday	5/23/17	Group Meeting	4:00-5:15 p.m.
Tuesday	5/30/17	NO GROUP	NO GROUP
Tuesday	6/6/17	Group Meeting	4:00-5:15 p.m.
Tuesday	6/13/17	Group Meeting	4:00-5:15 p.m.
Tuesday	6/20/17	Optional Make-Up Session (for those who missed a scheduled session)	

Visit us on the Web at www.childrensprogram.com