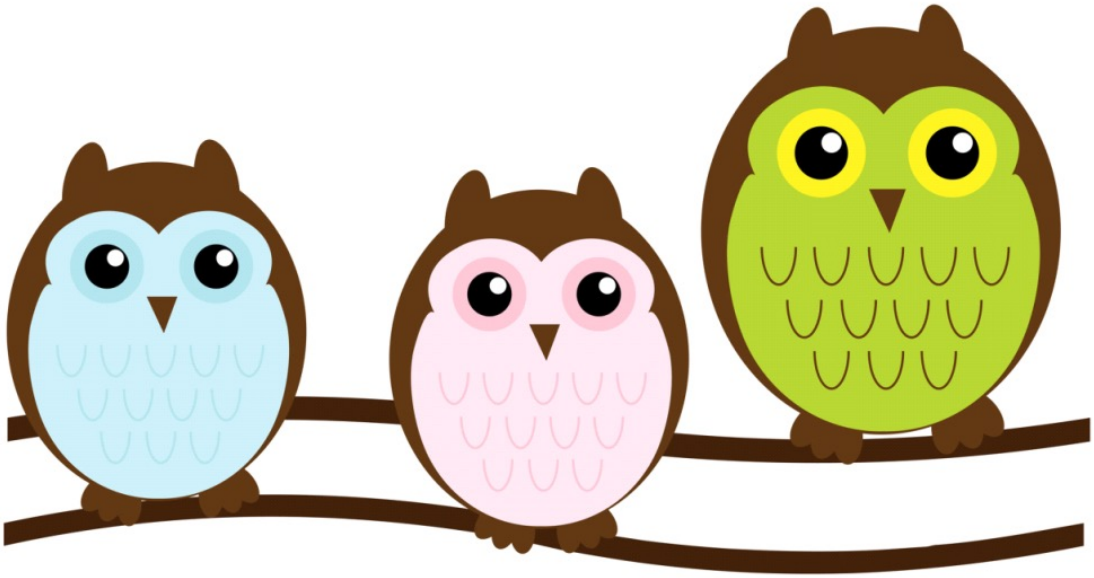
GIRLS GROUP

Information and Registration Packet

Thursdays from 4PM – 5PM

October 12th – November 16th, 2017

Kayla Hoskins, M.S., CSWA



What is GIRLS GROUP?

This group coaches girls in grades 4 and 5 through adapting to their ever-changing selves and relationships. We address many different areas of a young girls' life, including trouble creating and/or maintaining friendships, problems processing emotions, and low-self-esteem or overall negativity. Through group discussions and activities designed to help promote problem-solving and coping strategies we will address common themes that occur at this age, including navigating a growing social world, building up a health self-image and managing the stress that comes with increasing responsibilities at home and school.

Who is leading GIRLS GROUP?

Kayla Hoskins, M.S., CSWA**,** Is an Honors program graduate from University of Oregon and earned her Masters of Science degree in Advanced Clinical Social Work Practice from Columbia University in New York City, specializing in Health, Mental Health, and Disabilities. Kayla has experience in school and various healthcare settings, and has worked extensively with children and families from diverse backgrounds. She enjoys helping each individual she works with to reach their full potential within their environment. Her current interests include early childhood, developmental and behavioral problems, and mindfulness. Kayla utilizes family-systems and cognitive behavioral strategies, and has experience and training in dialectical behavioral therapy, trauma focused cognitive behavioral therapy, collaborative problem solving, and acceptance and commitment therapy. She works with young children, providing individual and group therapy to address behavioral and emotional concerns.

If your child is not a current patient of Children's Program, please schedule a complimentary 30-minute initial consultation.

FAQs

What is the cost of the group? The cost is $180 per child for 6 weekly sessions.

What are the times/dates of the group? Thursdays from 4:00 PM – 5:00 PM. Dates are October 12th, 19th, and 26th, and November 2nd, 9th, and 16th.

What if we miss one? The program is considered a "package" service. There is no credit for sessions that are missed and cannot be billed to your health insurance. There is no make-up class.

Do you bill insurance? This group is not insurance billable.

Can we talk after at the end of group? Please try and keep the check-in short, or arrange some time 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.

Where do we wait? Wait for class to begin in the waiting room. I encourage parents to wait for their child during the first session, and if all goes smoothly, then please be back to pick up your child at the end of the session.

What about bad weather? In case of inclement weather, please call the office (503) 452-8002 to check if group will be held. All families are asked to provide an email address for contact purposes.

Therapy Group Registration Form

☐ **Spring** ☐ **Fall** ☐ **Winter**

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 ☐ other groups

Group/Class Name _____

Dates/Times _____

Please read the Financial Policy for Therapy 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 # 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 choose to cancel your registration within 3 business days of the start of the group you will incur a $25 administrative fee. We reserve the right to refund your registration by check.

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 the Children's Program along with your completed registration packet.

6443 SW Beaverton-Hillsdale Hwy, Suite 300, Portland, OR 97221
Fax to (503) 452-0084

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. We will attempt to remind you of your appointment via email, text and telephone.

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

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. Evaluation appointments require a one week notice. 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 PRIMARY CARE PROVIDER. I consent to the Children's Program exchanging information as appropriate.

_____

Name of Primary Care Provider **Group Affiliation if Applicable**

_____

Office Address

I have read and authorized the above.

_____

Financially Responsible Party/Legal Guardian Date Relationship to client

REGISTRATION CHECKLIST

GIRLS GROUP

Did You:

1. Complete the **Registration** form. **Payment in full must accompany the registration.**

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

3. Read, sign, and return the Consent for Payment and Health Care Operations form. Your credit card numbers MUST be included for your registration to be processed unless you are paying in full.

4. Read, sign, and return the Treatment Consent form.

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