PHONE
503.972.0235
TOLL FREE
1.866.972.0235
WEBSITE
WWW.OREGONIH.COM

OREGON INTEGRATED HEALTH

PORTLAND LOCATION
1427A NW FLANDERS ST
PORTLAND OR 97209

EUGENE LOCATION
1029 RIVER ROAD
EUGENE OR 97404

SALEM LOCATION
1535 LIBERTY ST SE
SALEM OR 97302

FLORENCE LOCATION
1441 7TH ST. SUITE B
FLORENCE OR 97439

Thank you for choosing Oregon Integrated Health as your Integrative Primary Care Clinic!

- Please arrive **10 minutes prior** to your appointment time with your paperwork already completed. This will help our staff to have you ready to see your physician on time.
- New patients must arrive to their first patient appointment **10 MINUTES prior** to complete paperwork or have completed paperwork prior to appointment. You may be rescheduled without completed paperwork.
- Our office will contact your insurance company to verify coverage and benefits. Please verify your coverage and that you are active on your health plan prior to your appointment. Co-payments, Co-insurance, Lab Payments and Deductible amounts are payable at the time of service. We accept,, Visa, MasterCard. Please note Oregon Integrated Health does not accept cash or checks.
- Late Appointments are considered if you arrive 10 minutes or more past your appointment. You will be asked to reschedule. We strive to see every patient as close to their appointment time as possible. We ask that you please be courteous of your provider's valuable time and attention.
- OIH will contact you via phone, text message and email if applicable. If you have a preference please notify the front desk or schedulers.

Appointment Policy

Our office requires 24 hour notice if an appointment cannot be kept or needs to be cancelled. **You can text our main office number #CANCEL between 8am and 5pm**. If before 8am or after 5pm, please leave a message on our voicemail. We make every effort to provide reminder calls, text messages and emails 48hr and 24hr before your scheduled appointment.

All "No Show" appointments are tracked within the patient's medical record. There is a $50.00 fee attached to all "No Show" appointments subsequent to the first offense. Patient's will receive a text message notifying of missed daily appointments. If you have pending future appointments these will be cancelled unless you confirm that you will be attending these appointments. Each patient is provided same day opportunity to reschedule. After three (3) missed appointments, the practice may at its discretion choose to discontinue your care. New patients that No Show to their first 2 appointments are discharged from the practice.

Thank you, we look forward to meeting you soon.

Oregon Integrated Health

OREGON INTEGRATED HEALTH

Personal Information

First Name:	Middle:	Last Name:
Preferred Name:	Gender:	Date of Birth:
Age:	Preferred Phone Number:	Alternate Phone Number:
Email:		
Mailing Address:		
City:	State:	Zip:
Ethnicity:	Preferred Language:	Race(s):
OIH Primary Care Provider:	Preferred Pharmacy:	
Emergency Contact Name:	Emergency Contact Relationship to You:	Phone Number:

GUARANTOR - PERSON FINANCIALLY RESPONSIBLE FOR PATIENT ACCOUNT
ONLY COMPLETE IF YOU ARE NOT THE GUARANTOR

Patient Relationship to Guarantor: SPOUSE CHILD OTHER:

Guarantor Name:	Guarantor Phone:
Guarantor Date of Birth:	Guarantor Address if Different than Above:
Guarantor Address if Different than Above:	

OREGON INTEGRATED HEALTH

Phone: 503.972.0235
Toll Free 1.866.972.0235
www.oregonih.com

HIPAA - CONSENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to the use and disclosure of my protected health information for all practitioners of Oregon Integrated Health, (OIH), for the purposes of treatment, coordination of care, payment and healthcare operations, or as otherwise required by law.

I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Oregon Integrated Health prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.

I have the right to request restrictions to the usage and disclosure of my protected health information.

I have the right to request an alternative to the standard method of communication of my protected health information.

I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that Oregon Integrated Health may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Oregon Integrated Health at the following address:

OIH Administration Office: 2459 SE Tualatin Valley Hwy #416 Hillsboro, OR 97123

I understand that if I have any questions or complaints I may submit them in writing to the address above or contact Oregon Integrated Health by phone at 503.972.0235 ext 2108 or office@oregonih.com.

I am aware that Oregon Integrated Health reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Oregon Integrated Health will make available a revised Notice of Privacy Practice for my review.

FINANCIAL POLICY

- **Payment is due at the time of service**: ALL SERVICES NOT COVERED BY YOUR HEALTH, DENTAL, MVA OR WORKERS COMPENSATION INSURANCE ARE PATIENT/GUARANTOR RESPONSIBILITY. Credit card payments will be accepted at time of visit, over the phone or payments may be made online. All services, deductibles, co-pays, co-insurances, outstanding balances, supplies, lab work, tests as well as any additional expenses incurred in connection to your health not covered by your insurance is your responsibility. If requested, a copy of services provided will be given to you.
- **You agree that all information you have provided on all forms are true to the best of your knowledge.** If incorrect information is provided or you do not disclose full insurance information payment for all services rendered will be your responsibility. All information written is a patient/guarantor full responsibility, OIH is not responsible for information provided to us that is illegible or may be misinterpreted.

- **Office Services**: If you have health/dental insurance, **Oregon Integrated Health** will assist with verifying eligibility for office visits pertaining to your scheduled appointment at our clinic. The verification of your benefits, lab services, motor vehicle accident, or workers' compensation insurance is used to determine if there is coverage for services through your insurance carrier and is NOT a guarantee of payment by your insurance carrier. Your signature here designates that you understand you are fully responsible for being aware of any coverage exclusions and any payments. Contact your member services regarding your coverage information before your visit our clinic to ensure that you understand your coverage, costs for all services that you will receive at our clinic.
- **Co-Pays, Deductibles, and Co-Insurances:** Please note we only file for your insurance's share of services provided. The patient's share of co-pays, deductibles, and co-insurance are due at the time of service.
- **Secondary Insurances:** Secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment.
- **Lab Payments:** It is patient responsibility to verify your lab benefits with your insurance, please notify the front desk of specific lab requirements.
- **No-Show Appointments:** The following fees will apply for "no-show" appointments:
    - There is a $50.00 fee attached to all "No Show" appointments subsequent to the first offense.
    - After three (3) missed appointments, the practice may at its discretion choose to discontinue your care
    - New patients that No Show to their first 2 appointments are discharged from the practice.
- **Statements**: Statements are mailed out monthly. OIH will collect the balance prior to your next appointment.
- OIH reserves the right not to schedule you an appointment until a payment plan or payment in full has been placed on your account.
- Patients will be sent to collections after 4 missed payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical/dental and clinical benefits, to Oregon Integrated Health. I hereby authorize and direct my insurance carrier(s), including Medicaid, Medicare, private insurance and any other health/medical/dental plan, including motor vehicle and workers compensation to issue payments/check(s) directly to Oregon Integrated Health for all services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Oregon Integrated Health to: (1) release any information necessary to insurance carriers regarding my illness and/or treatments: (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested health services - which may include medical, oral health, mental/behavioral health and any other clinical service that I make an appointment with from Oregon Integrated Health. On behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

CONSENT OF TREATMENT

I will complete all information on health history and demographic forms accurately and verify this information is true to the best of my knowledge. I consent to all clinical/medical/oral health treatments from all providers at Oregon Integrated Health and authorize my insurance benefits be paid directly to the provider and/or Oregon Integrated Health. I understand that I am financially responsible for any balance per the financial policies of Oregon Integrated Health. I also authorize Oregon Integrated Health or insurance company to release any information required to process my claims.

COMMUNICATIONS

You acknowledge that communications with Oregon Integrated Health and/or the providers using email, SMS and phone and/or mobile devices such as; iPads, laptop computers are not guaranteed to be secure or confidential methods of communication. Oregon Integrated Health uses HIPAA compliant conduit applications. You acknowledge that all such communications may become a part of your medical record. Telemedicine visits are not recorded or stored. You are acknowledging and confirming your consent to receive such messaging to document your compliance with the Telephone Consumer Protection Act (TCPA). You authorize Oregon Integrated Health to communicate with you by e-mail or SMS regarding your "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations) using the e-mail address and phone number you provide to ClinicOps. By providing OIH with your e-mail address and phone number, you acknowledge that: although Oregon Integrated Health and the Provider will make reasonable efforts to keep e-mail and SMS communications confidential and secure, neither OIH nor the provider can assure or guarantee the confidentiality of e-mail or SMS communications; e-mail and SMS communications may be made a part of your permanent medical record; E-mail and SMS is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. If you choose to opt out of email and/or SMS please notify the front desk.

My electronic signature certifies that I have read, understand and agree to the terms of Oregon Integrated Health, HIPAA Notice of Privacy Practices, Financial Policy, No Show Cancellation Policy, Assignment of Benefits, Authorization to Release Information and Consent to be Treated. I agree that all information I have provided is accurate and true to the best of my knowledge. **Date Signed**_____

Patient Signature (18 years or Older) _____ **Full Name**_____**DOB**_____

Guarantor Signature: I hereby acknowledge that I am financially responsible for payment of all services rendered to the above named patient that I am subject to all financial terms.

Guarantor Full Name: _____ **Signature** _____ **Date Signed**_____

Oregon Integrated Health Telemedicine Consent

I understand that my OIH healthcare primary care clinic wishes me to engage in a telemedicine consultation.

OIH has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by Medical Assistants at my location at the direction of the consulting health care provider.

I have had a direct conversation with my healthcare primary care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me;

That I have had the opportunity to ask questions about the information presented in this form and that any questions have been answered to my satisfaction.
That I fully understand its contents including the risks and benefits of the procedure(s).

Date of Birth: _____

Patient's/Parent/Guardian Signature _____

Todays Date :_____

OREGON INTEGRATED HEALTH

Young Child Health History Form

Child's Name:_____
First Middle Last

Child's Address_____

Today's Date_____

Filling out this form

- Answering these questions will help your doctor understand your child's health and how best to treat your child.
- If you need help filing out this form:
  - Please return this form PRIOR to your visit

GENERAL INFORMATION

What is the child's sex? ☐ Female ☐ Male

Child's Date of Birth_____ current age _____

Is your child **adopted**? ☐No ☐Yes If yes, at what age? _____

Who is filling out this form?
☐Mother

☐Father

☐Other guardian (please explain relationship to child) _____

☐Other (please explain) _____

The child's parents are:

☐Single ☐Married ☐Divorced ☐Separated but not divorced

☐Widowed ☐Living together but not married ☐Unknown

Main adult contact for child	**Other adult contact for child**
Name:	Name:
Relation to child: ☐ Mother ☐ Father ☐ Other: _____	Relation to child: ☐ Mother ☐ Father ☐ Other: _____
Address: ☐ Same as child's Street address: _____ _____ City: _____ State: _____ Zip: _____	Address: ☐ Same as child's Street address: _____ _____ City: _____ State: _____ Zip: _____
Home Phone:	Home Phone:
Cell Phone:	Cell phone:
Work Phone:	Work Phone:

TODAY'S CONCERN

1. List your child's **main health problems** (or reasons for visiting the clinic).

☐ Routine checkup
☐ Immunizations (shots)
☐ A health problem (please specify)_____
☐ Switching doctors (last doctor _____)

2. How well do you feel your child **acts or behaves**?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

MEDICAL HISTORY

3. Has your child ever been a **patient in a hospital** (other than a few days after birth)?

☐ No (If no, go to question #4.)
☐ Yes (If yes, explain why and when below.)

My child was in the hospital because:	When
Example: Bike accident	5 years old

4. Is your child taking any **prescription medicines**?
☐No. My child does not take any prescription medicines. (If no, go to question #5.)
☐Yes - Please list the child's medicines below or ☐I brought my child's medicines.

Name of medicine	Amount / size of pill	How many pills or doses does your child take at
Example: Dexadrine	10 mg	__1__morning ____noon ____evening __1__bedtime
		____morning ____noon ____evening ____bedtime
		____morning ____noon ____evening ____bedtime
		____morning ____noon ____evening ____bedtime

(Please use the back of this form if you have more prescription medicine.)

5. What **over-the-counter medicines**, does your child take regularly?
☐ Vitamins
☐ Herbal medicine (please list) _____
☐ Other (please list) _____
☐ None, my child does not take any over-the-counter medicines regularly.

6. Does your child have any **allergic reaction (bad effect)** from any of the following? (Check all that apply.)
☐ Outside or Indoor allergies (for example: grass, pollen, cats …)
☐ Food Allergies (for example: peanuts, milk, wheat …)
☐ Medicine or shots (immunization). (Please list below.)
☐ No, my child has no allergies that I know of.

Medicine child is allergic to:	What happens when the child takes that medicine

Example: Amoxicillin	Diarrhea (runny poop)

7. Has your child had any of the following **diseases**?

Measles	☐Yes	☐No	☐Don't Know
Mumps	☐Yes	☐No	☐Don't Know
Chicken Pox	☐Yes	☐No	☐Don't Know
Whooping Cough	☐Yes	☐No	☐Don't Know
Rubella	☐Yes	☐No	☐Don't Know
Rheumatic Fever	☐Yes	☐No	☐Don't Know
Scarlet Fever	☐Yes	☐No	☐Don't Know

8. Please check any of the following **issues** that your child has **ever** had.

Has your child **ever** had:	
Ear infections	☐ Yes ☐ No
Nose problems (sinus infections, nose bleeds)	☐ Yes ☐ No
Eye problems (blurry vision, need to wear glasses)	☐ Yes ☐ No
Hearing problems	☐ Yes ☐ No
Mouth or throat problems (Strep throat, swallowing problems)	☐ Yes ☐ No
Diarrhea (having frequent and runny bowel movements/poop)	☐ Yes ☐ No
Constipation (problems having a bowel movement /poop)	☐ Yes ☐ No
Throwing up (vomiting)	☐ Yes ☐ No
Problems **peeing** (bed wetting, pain when peeing)	☐ Yes ☐ No
Back problems (crooked back, back pain)	☐ Yes ☐ No
Growing pains (bone or body pains due to growing)	☐ Yes ☐ No
Muscle and bone problems (weak muscles, pain in joints)	☐ Yes ☐ No
Skin problems (acne, flaking skin, rashes, hives)	☐ Yes ☐ No
Seizures (shaking fits)	☐ Yes ☐ No
ADD/ADHD (problems paying attention, sitting still)	☐ Yes ☐ No
Sleeping problems (falling or staying asleep)	☐ Yes ☐ No

Breathing problems (cough, asthma)	☐ Yes ☐ No
Behavioral Issues (please list)	☐ Yes ☐ No
Other Issues	☐ Yes ☐ No

SHOTS

9. Has your child received **immunizations (shots)** in the past?

☐ No (If no, go to question #10.)

☐ Yes

If yes, have you given this office a copy of the immunization (shots) records?

☐Yes (If Yes, go to question #10.)

☐No

If not, **please give us the name of the doctors' offices or clinics** where your child has received these shots so we can get the records.

Doctor's office/clinic name: _____

Doctor's office/clinic phone number:_____

ABOUT MOM WHEN PREGNANT

The following questions are about the mother of the child during pregnancy and birth.
If you do not know about the pregnancy of the mother, check here ☐ and go to question #17.

10. What was the general **health of the mother** during pregnancy?

☐ Excellent ☐ Good ☐F air ☐ Poor ☐ Unknown

11. Were any of the following used **during pregnancy**?

☐ Cigarettes

☐ Alcohol

☐ Illegal drugs (which ones? _____)

☐ Prescription drugs (which ones? _____)

☐ None of the above

12. Did the mother have any of the following **conditions or problems during pregnancy**?

☐ Preeclampsia (high blood pressure) ☐ Diabetes (sugar)

☐ Emotional stress ☐ Injury or serious illness

☐ Unexpected bleeding or spotting ☐ Other _____

13. **Was the birth**:

☐ On the due date

☐ Before the due date (by how much_____)

☐ After the due date (by how much_____)

14. **Was the birth:** ☐Vaginal? ☐C-Section (surgical cut in the tummy)?

15. **Were any of the following used**?

☐ Pain medicine during birth (epidural)

☐ Tool to help pull baby out (forceps or vacuum)

☐ None

16. Were there any **problems during the birth**? ☐ Yes ☐ No

If yes, please explain: _____

ABOUT THE CHILD AS A BABY

17. Was/is the child **breastfed**? ☐ Yes ☐ No If yes, how long_____

18. In the first **2 months after birth**, did the child have:

☐ Jaundice (yellow skin)

☐ Colic (upset stomach, crying)

☐ Breathing problems

☐ Other _____

☐ None of the above

19. At what age did the child begin to **crawl**? _____

20. At what age did the child begin to **sit up**? _____

21. At what age did the child begin to **walk**? _____

22. At what age did the child get his/her **first tooth**? _____

23. At what age did the child began to **say words** (mama, dada)? _____

24. How would you rate your **child's health in his or her first year** of life?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unknown

IN SCHOOL AND AT HOME

25. Does the child go to **school or daycare**? ☐ Yes ☐ No If yes, what is its name?

SCHOOL:
DAY CARE:

26. If your child goes to school or daycare, describe **how your child acts** in school or daycare.

Check all that apply.

☐ Nervous, worried
☐ Hyper, restless, can't sit still
☐ Pushy, bullies others
☐ Relaxed, calm
☐ Social, friendly
☐ Shy, withdrawn, keeps to self
☐ Gets angry easily
☐ Scared, fearful
☐ Moody
☐ Happy

27. How are your child's **grades** in school?

☐ Excellent ☐ OK ☐ Poor ☐ Does not go to school

28. About how much **exercise** does your child get every day?

☐ Less than 30 minutes ☐ 30 minutes to 1 hour ☐ Over 1 hour

29. About how many hours of **TV** does your child watch every day?

☐ Less than1 hour ☐ 1-3 hours ☐ More than 3 hours

30. About how many hours is your child on a **computer** every day?

☐ Less than 1 hour ☐ 1-3 hours ☐ More than 3 hours

☐ Does not have a computer

31. About how many hours does your child **spend outside** every day?

☐ Less than1 hour ☐ 1-3 hours ☐ More than 3 hours

32. About how many hours are **spent reading** with your child every day?

☐ Less than 15 minutes ☐ 15-30 minutes ☐ 30 minutes to1 hour ☐ More than 1 hour

33. Does your child **wear a helmet** when riding a bike, roller blading, skate boarding, etc.?

☐ Yes ☐ No ☐ Does not do activities like that

34. Does your child get **buckled in a car seat** or **wear a seat belt** when riding in a car?
☐Yes ☐ No

35. Do you have **guns** in the home? ☐Yes ☐ No
If yes, are they **locked up**? ☐Yes ☐ No

36. What **activities** is your child involved in:

☐ Riding bike ☐T-ball/baseball ☐ Dance/movement ☐ Skate boarding
☐ Karate ☐ Video games ☐ Girl Scouts/Boy Scouts
☐ Soccer ☐ Playing a musical instrument
☐ Reading ☐ Playing with friends

Other team sports _____
☐ Other activity(s) _____
☐ Too young to be involved in activities

37. Please list what your child typically **eats and drinks in a day** for:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

FAMILY

38. Check all the people that the **child lives with**:

☐ Mother
☐ Father
☐ Brothers (how many? _____)
☐ Sisters (how many?_____)
☐ Other family members (list _____)
☐ Friends or other people (list_____)

☐ Animals ☐ Dogs (how many?_____) ☐ Cats (how many?_____)

☐ Other animals _____

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0352

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

11-21/rev0303

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, your rights concerning your health information, and our legal duties. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect October 1, 2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices in the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, coordination of care, payment, and healthcare operations to *all* practitioners at Oregon Integrated Health.

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Coordination of Care: We may use and disclose your health information to to a physician or other healthcare provider providing treatment to you to ensure the safety of your care provided does not conflict or cause harm and is therapeutically effective.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, coordination of care, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Minors Under the Age of 18: The parent may have access to the medical records of the minor related to treatment when State or other applicable law requires or permits such parental access.

Behavioral, *Mental Health & Chemical Dependency:* We may disclose your health information to other providers at Oregon Integrated Health to ensure safe coordination or care and treatments.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

PATIENT RIGHTS *Access*: You have the right to get copies of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that :

- We did not create
- Is not part of the health information that we maintain
- You would not be permitted to inspect and copy
- Is accurate and complete

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Electronic Notice: If you receive this notice on our web site or by e-mail, you are entitled to receive this notice in written form.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. To file a complaint please contact us at the number or address listed on the top front page of this notice. You will not be penalized for filing a complaint.