Valerie Tobin, PMHNP, LLC
516 SE Morrison St. Suite 610, Portland, OR 97214 p. 503-318-8568 f. 503-345-6899

CLIENT'S FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ OTHER _____

May we leave you a message on your phone? Yes/No May we leave information regarding: Appt / Billing / Clinical

Would you like to receive appointment reminders? Email Home phone Cell phone Text No Reminder

EMAIL _____ May we email you information regarding: Appt / Billing

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

WHOM MAY I THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY INFORMATION: Patient Statements will be sent here.

NAME _____ DATE OF BIRTH: _____

SOCAIL SECURITY# _____ RELATIONSHIP TO PATIENT _____

☐ Check here if address is the same as Clients

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE # _____

I am responsible for all charges for all services provided by Valerie Tobin, PMHNP, LLC.
Please note that partners can not sign on each other's behalf. The person who is listed as the responsible party must sign.

_____

Responsible Party Signature Date

PRIMARY INSURANCE: _____ TELEPHONE: _____

POLICY #: _____ GROUP #: _____

SUBSCRIBER: _____ DATE OF BIRTH: _____ RELATIONSHIP TO PTN _____

☐ Check here if address is the same as Clients

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE # _____

I hereby authorize In Its Place and Valerie Tobin, PMHNP, LLC to: 1. furnish my insurance company with any/all information requested concerning my/my child's present claim(s), including records if requested, 2. bill my insurance company, and to accept payment from that company on my behalf, for all services relating to my care.
I acknowledge that I am responsible for all charges not covered by my insurance. Any money credited as overpayment due to me will be refunded after completion of treatment.

_____

Primary Insured Party Signature Date

PLEASE NOTE THAT PARTNERS CAN NOT SIGN ON EACH OTHER'S BEHALF. THE PERSON WHO IS LISTED AS THE PRIMARY INSURED MUST SIGN.

Valerie Tobin, PMHNP, LLC
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Consent To Treatment

Welcome to the practice of Valerie Tobin, PMHNP. My role is to help your child or adolescent reach her or his optimal development. As a parent, your participation and openness are vitally important to this process. I strive to create a safe and therapeutic environment in which we will develop, refine, and pursue meeting mental health goals for your child or teen.

Valerie Tobin, PMHNP

I am licensed as a Psychiatric Mental Health Nurse Practitioner within the state of Oregon. I completed a master's degree in Advanced Practice Pediatric Nursing and a post-master's in Child and Adolescent Psychiatric Mental Health Nursing at the University of California, San Francisco. I have additional specialty training in adolescent medicine and developmental behavioral pediatrics. I was privileged to be the first nurse practitioner student invited to study with psychologists and psychiatrists in Children's Hospital Oakland's psychiatry department. This training included medication management in children and adolescents and psychotherapy with children, adolescents, and families. I hold national board certification as a Clinical Specialist in Child and Adolescent Psychiatric Mental Health Nursing. My undergraduate degree is in sociology from Bryn Mawr College, where I graduated magna cum laude, with honors.

Confidentiality

This is consistent with my HIPAA Notice of Privacy Practices.

Parent/guardian participation in child/adolescent treatment

My policy is to have the custodial parent consent to treatment for any child under the age of 14 for mental health and under the age of 15 for medical treatment. My policy is to include both parents in the treatment unless there are specific reasons not to do so. Please be aware that in most instances, both parents are allowed access to the child's treatment records. What you disclose to me related to the treatment of your child may be entered into the child's treatment record. If conflict between parents or if a parent's needs are interfering with a child's mental health and development, I will make a referral for individual or couple's counseling. I do not provide individual or couples counseling to the parents of my patients.

Contact with other health care providers

I believe that it is important for myself and all other persons providing health care to your child to be in touch. Generally I will ask you to sign an Authorization to Use and Disclose Protected Heath Information so that I can speak to your child's therapist, primary healthcare provider, specialist healthcare provider, school counselor, and parent's therapist, so that I can fully assess and treat your child or adolescent.

Length and type of treatment

Duration of treatment varies depending on individual client needs. Participation in psychotherapy is a vital part of recovery and I recommend it for all clients, with myself or another therapist. Should you not schedule an appointment for 60 days and make no arrangement in writing with this provider for said time, you will no longer be considered an active client of Valerie Tobin, PMHNP and therefore have terminated treatment. If you fail to show to an appointment without calling at least 24 hours in advance to cancel an appointment two times, or fail to show without 24 hours notice once and do not call within 30 days to reschedule you will be considered to have terminated treatment with Valerie Tobin, PMHNP.

Client's Name: _____ Date of Birth:_____

Medication management

All medications have the potential for causing side effects in some individuals, including herbal preparations. It is the responsibility of each parent to inform me of any adverse side effects from medication. Unfortunately, we have no way of testing which persons will have which side effects to which medications. Please be advised that medications used in child psychiatry are often prescribed "off-label" for children, meaning that they are prescribed to control symptoms other than those that the FDA originally approved for the medication or the FDA has not approved the medication for use in children/adolescents. Despite the need, very few psychiatric medications are tested by pharmaceutical companies for use in children and adolescents. In addition to my original education, the information I use to determine appropriate psychiatric medication is reading peer reviewed journals, consulting with other PMHNPs and MDs, and through continuing education, at least 100 hours every two years.

Risks

While psychiatric care is beneficial to many people, I cannot guarantee that your child will improve. One of the risks of therapy or medication is the risk that clients will not improve, or will get worse.

Legal issues

It is my policy never to participate in any legal proceedings involving current or former clients. This means that, except as required by law, I will not testify in cases of divorce, custody, competency, or any other legal actions. I have this policy because our treatment may be damaged if it is not confidential and I may be forced to terminate treatment. I am not conducting a custody evaluation, risk assessment for school, or an abuse investigation. If you or I believe that any of these need to be conducted, those services would be obtained from another independent professional who would be the one to give the results directly to your attorneys. With your permission and/or under legal guidelines, I would provide information directly to the qualified professional or agency conducting those investigations to assist in their research and recommendations.

Regarding Issues of Divorce or Separation

It is essential for the benefit of your child that I maintain neutrality in any divorce or custody-related disputes. If you have unresolved feelings about your ex-spouse and your own adjustment to divorce and visitation issues, these should be addressed with your own therapist and not with me, your child's therapist. I will discuss with each parent only issues with their child occurring in their own household. My role is not as a "go-between" to share information about one household with the other. If conflicts between separated parents are interfering with a child's mental health and/or therapy, I will refer parents to mediation or a parenting coordinator.

SIGNATURE

I understand and agree with the treatment conditions as stated above. I understand that if the terms of this agreement are violated, therapy and/or medication management may be damaged and may require termination.

By: _____ (individual or personal representative)

Date: _____

Description of personal representative's authority:_____

Clients over 14: _____

Client's name: _____ Date of Birth: _____

Valerie Tobin, PMHNP, LLC
516 SE Morrison St. Suite 610, Portland, OR 97214 p. 503-318-8568 f. 503-345-6899

Office Policies

This statement is to familiarize you with my office policies. Your signature signifies that you have read, understand, and agree to abide by these policies and that you have received a copy of these policies for yourself or declined a copy.

Fees: Full fee schedule available upon request. The following services are usually not reimbursed by health insurance.

Appointments missed or canceled with less than 24 hours notice……	$130
Telephone consultations between PMHNP and client or family ……	$50-$100
telephone calls are charged based on current American Medical Association rules	
Online clinical consultation ……..……	$25
Rebilling fee ……	$20
Returned check fee ……	$15

Office Hours: Monday through Thursday. Hours vary.

Payment*:* Please make checks payable to Valerie Tobin, PMHNP, LLC. You may also pay with Visa or MasterCard. If payment is not received services may be discontinued. If you do not pay as agreed, your account may be turned over to an attorney or a collection agency and you will be held responsible for any legal or collection costs incurred.

Insurance: You can leave a message at this office number for Amber Flores of In Its Place regarding billing questions. You are responsible to check with your insurance company regarding your coverage and to track your coverage. Until the evaluation is completed, I am unable to bill insurance because no diagnosis is made without a full evaluation. A diagnosis is required to bill insurance. You are responsible for all charges not covered by your insurance company. ***Co-payments are due at the time of service.***

Cancellations: ***Please call to cancel with at least 24 hours notice; this includes weekends if your appointment is on a Monday. If you fail to cancel your appointment with 24 hours notice, you will be charged $130. The evaluation process will stop for any new patients who no show or cancel with less than 24 hours notice. Insurance companies will not pay for missed appointments and you will be responsible for the $130 cost of the missed appointment. If you miss your appointment due to traffic or other concerns, the same rule applies.***

Emergencies: For after hours emergencies please call 911 or go to the nearest emergency room. After hours and on weekends you may leave a message at my cell phone 503-358-8279. Texts will not be answered.

Urgent Calls: You may leave a message at my cell phone 503-358-8279 after hours and on weekends. Texts will not be answered. Urgent needs include new or increasing suicidal thoughts, concerning side effects of medications, and worsening mental illness. Calls related to appointment changes and prescription refills should be left at the office phone number 503-318-8568. These are not considered urgent needs and cell phone calls regarding these issues will not be returned.

Name of client: _____ Date of Birth: _____

Email: I have a secure email system for your consultations. Consultations include email responses to family, patients, therapists, and schools, and which provide recommendations for treatment and/or school accommodations. I will not make recommendations about starting medications or changing medications online. This requires an office visit. Emails are checked and answered during regular office hours. This email is valerie@valerietobin.com. For scheduling and billing questions please email my assistant at info@valerietobin.com.

Prescription Refills: Refills of medication are usually written at the time of the appointment. Refills are not an emergency and will be handled between 9 and 5pm within 48 business hours.

Grievance Procedure: I encourage you to discuss your complaint with me directly to resolve the problem/issue. I hope always to learn from these discussions. You may also contact your insurance company or the Oregon State Board of Nursing at: 17938 SW Upper Boones Ferry Rd, Portland, OR 97224-7012 or (971) 673-0685.

HIPAA Notice of Policies and Practices: I am required by Federal law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State law to protect the privacy of your personal information and to give you a notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the *HIPAAA Notice of Policies and Practices* should you wish to have a complete copy for your records.

SIGNATURE

Your signature below indicates that you have read this agreement and agree to all of its terms. You understand that if the terms of this agreement are violated, your child's therapy may be damaged and may require termination. Your signature also serves as an acknowledgement that you have received that HIPAA Notice of Policies and Practices described above if you have requested it.

By: _____ (signature of personal representative, i.e. parent/guardian) Description of personal representative's authority: _____ Clients over 14: _____ (signature) Client's name: _____ Date of Birth: _____	Date: _____

516 SE Morrison St. Suite 610, Portland, OR 97214 p. 503-318-8568 f. 503-345-6899

Parent Questionnaire Adolescent

Name of adolescent: _____ Date of birth: _____

Date: _____ Person filling out form: _____Relation to adolescent: _____

What is your reason for seeking mental health care for your adolescent? _____

_____

Allergies to food or medicine: None or list food or medicine and reaction:_____

_____

Current medication(s), vitamins, or herbal preparations? Name and amounts:_____

_____

Primary Care Practitioner Name: _____

Address: _____

Phone: _____ Fax: _____

Preferred Pharmacy Name: _____

Address: _____

Phone: _____ Fax: _____

Is your adolescent currently seeing a therapist? No or Name:_____

Address: _____

Phone: _____ Fax: _____

Has your adolescent ever been diagnosed with a mental health condition? No or name and date:

_____

Has your adolescent received mental health care in the past? No or

When _____ With whom _____

What was addressed _____

What was helpful and not helpful? _____

Health:

Current and past health issues: (circle all that apply)

Parent Questionnaire Adolescent

	CURRENT	PAST
Constitutional	Weight change, fatigue, poor growth/failure to thrive	Weight change, fatigue, poor growth/failure to thrive
Sleep	Snores, stop breathing at night, nightmares, trouble falling or staying asleep	Snores, stop breathing at night, nightmares, trouble falling or staying asleep
Eyes	Light sensitivity, tearing, poor vision	Light sensitivity, tearing, poor vision
ENT	Hearing loss, ringing in ears, frequent sinus infections, sore throat, tonsillitis, difficulty swallowing, problems with teeth	Hearing loss, ringing in ears, frequent sinus infections, sore throat, tonsillitis, difficulty swallowing, problems with teeth
Heart	Murmurs, irregular heartbeat, rheumatic fever	Murmurs, irregular heartbeat, rheumatic fever
Respiratory	Wheezing, cough, asthma, pneumonia, night time cough	Wheezing, cough, asthma, pneumonia, night time cough
Genitourinary	Loss of bladder control, frequent urination, painful urination, bed wetting	Loss of bladder control, frequent urination, painful urination, bed wetting after potty training completed
Muskuloskeletal	Muscle weakness, arthritis, fractures, bone disease	Muscle weakness, arthritis, fractures, bone disease
Gastrointestinal	Heartburn, abdominal pain, nausea, vomiting, constipation, diarrhea	Heartburn, abdominal pain, nausea, vomiting, constipation, diarrhea
Skin	Rashes, itching, scratching	Rashes, itching, scratching
Neurologic	Headaches, dizziness, fainting, seizures/epilepsy, head injury, tics	Headaches, dizziness, fainting, seizures/epilepsy, head injury, tics
Endocrine	Diabetes, thyroid problems, hormone problems	Diabetes, thyroid problems, hormone problems
Hematologic	Easy bruising, bleeding problems, swollen glands	Easy bruising, bleeding problems, swollen glands
Immune	Frequent infections, allergies	Frequent infections, allergies

Other health conditions/concerns: _____

Has your teen ever been hospitalized? _____

Has your teen ever had surgery? _____

Client's Name: _____ Date of Birth: _____

Parent Questionnaire Adolescent

Has any member of your adolescent's family been diagnosed with the following:

Condition	*Relative*	*Details*
Neurologic condition (migraines, seizures, etc)		
Sudden cardiac death (note age)		
Diabetes		
Hyper/Hypothyroid		
Mental Health Condition (s)		
Drug/Alcohol Abuse		

Development:

Was your adolescent adopted? No or Yes. If yes, age at adoption: _____
If yes, please answer questions about prenatal and birth period to the best of your ability.

Were there any complications during the pregnancy or birth? No or please explain:
_____

Was the adolescent exposed to any medications, drugs, and/or alcohol during pregnancy?
No or please explain: _____

At what age did your adolescent walk? _____ speak words? _____Potty train? _____

What consequences do you have for negative behavior? _____
_____

What rewards do you have for positive behavior? _____
_____

School:
School: _____ Grade: _____

Typical grades: _____

Special Education, 504 Plan, or IEP? No or Yes for: _____
If yes, please bring a copy of the 504 Plan or IEP to our appointment.

If your adolescent has had psychological testing or educational testing with the school or outside of school, please bring a copy to the appointment.

Thank you!

Parent Questionnaire, Adolescent
Client's Name: _____ Date of Birth: _____

516 SE Morrison St. Suite 610, Portland, OR 97214 p. 503-318-8568 f. 503-345-6899

Adolescent Questionnaire

To be filled out by adolescent.

Name:_____ Date of Birth: _____

Today's Date:_____

What brings you to Valerie Tobin? _____

_____

_____

What would you like to improve or change by coming in? _____

_____

_____

Have you ever seen a therapist? No or Yes

If yes, what did you find helpful and not helpful. _____

_____

Are you experiencing any of the following?

☐ Trouble sleeping
☐ Getting in trouble a lot
☐ Changes in eating habits
☐ Easily annoyed
☐ Weight changes
☐ Crying a lot
☐ Failing in school
☐ Trouble breathing when stressed
☐ Nausea or vomiting or stomach aches
☐ Chest pain
☐ Problems getting along with friends or family
☐ Thoughts you cannot get out of your head even when you want to
☐ Trouble concentrating
☐ Sad
☐ Not enjoying usual activities
☐ Feeling guilty
☐ No energy
☐ Anger
☐ Not able to do homework
☐ Headaches
☐ Dizziness

How much caffeine do you drink? _____ cups per day or week

How many hours of sleep do you get nightly? _____

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Adolescent Questionnaire

What do you do before bed? _____

How often do you exercise: _____times per week. What type? _____

How much time do you spend on the computer daily? _____

How much time do you spend watching TV or playing video games daily? _____

What do you enjoy doing? _____

What makes you feel better when you feel bad? _____

Do you have someone you can talk to when you feel sad/stressed? Yes or No

If yes who is that_____

If you have any goals, what are they? _____

_____

Do you have any concerns about your health? _____

_____

Thank you!

Valerie Tobin, PMHNP, LLC
516 SE Morrison Street, Suite 610 Portland OR 97214-2347 p. 503-318-8568 f. 503-345-6899

CREDIT CARD AUTHORIZATION FORM

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, (parent)_____on behalf of (child)_____, authorize Valerie Tobin, PMHNP to charge my credit card for professional services rendered to myself or my child as follows:

Please Initial:

_____For balances of charges not paid by me at the time of service or by my insurance company (i.e., deductibles, copays / coinsurance, phone calls, letters, emails, and returned calls) as outlined in the office policies I signed.

_____For cancellations with less than 24 hours notice and for appointments I miss without notice as agreed to in the office policies I signed.

_____ On the _____ day of each month in the amount of $_____ per our signed payment arrangement

I understand this form is valid until I cancel the authorization in writing. I will not dispute charges ("chargeback") for sessions I have received or appointments I missed according to the office policies. I further understand that I am responsible for updating my credit card information in the event that it should change, and that I am responsible for any fees incurred for a declined credit card transaction.

I understand and agree that my card may be charged without me being present and that a receipt of payment will be sent to me within 48 hours of charges being placed on my card.

☐Visa ☐MC ☐Flex Card/FSA Benefit year _____

Card #: _____ Expiration Date: _____

Name on Card: _____3 digit code: _____

Billing Address (Street, City, State & Zip) :

_____

_____

Email Address: _____

Signature_____ Printed Name_____

Date_____

Charges will appear on your credit card statement as Valerie Tobin, PMHNP LLC