LIFEQUAL CENTER
Center for Health and Healing

Vijay Shankar, MBA, Psy. D Licensed Psychologist
Anne B. Shankar, MSQ, LCSQ Licensed Clinical Social Worker

Welcome, if you have landed on this page it is because you have set up an appointment with Vijay. Please take some time to complete the following forms. The more information that you can provide me the more efficiently we can use our intake session. Having said that, please know that you are welcome to choose to discuss any information in person if that is your preference.

1) **Patient Information**: Administrative and clinical. These forms provide basic personal data.

2) **Consent to Treatment**: Please read this carefully and do not hesitate to ask any questions that you might have. Please bring a signed copy to your New Client Appointment.

3) **Authorization to Exchange Information**: If you believe it would be beneficial to speak with a third party, such as your doctor, please fill out this form. If there are multiple people, I will need one form per person.

4) **Consent to Use and Disclose Your Health Information**: This summarizes information that is part of the privacy regulations of a federal law, the **Health Insurance portability and Accountability Act of 1996 (HIPPA)**. A comprehensive version is available upon request at the office. Please sign and bring to the session.

5) **Credit Card Authorization Form:** This is to process payments made by credit card of any balances if you would like LifeQual to charge the card without being present.

Please plan on staying on after the initial session for an hour to complete some questionnaires.

If using insurance:

1) Please be sure to bring your insurance card to your first appointment. We will need to keep a copy for our records.
2) Please also call your insurance company for pre-approval prior to the appointment. Failure to do so might result in their denying payment. If you receive an Authorization Number from them, please write that down in the form

If you have any questions, please do not hesitate to call my office at (503) 531-9355. During regular office hours.

Sincerely,
Vijay Shankar, Psy.D. Licensed Psychologist

1975 NW 167th Place, Beaverton, OR 97006
1962 NW Kearney, Suite 303, Portland, OR 97209
4000 Kruse Way Pl, Bldg. 2, Suite 330, Lake Oswego OR 97035

Phone: (503) 531-9355 Fax: (503) 629-8933
E-Mail: vijay@lifequalcenter.com URL: www.lifequalcenter.com

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I. Patient Information

First Name		MI		Last Name	
DOB		Home Phone		Cell	
Address				City	
State		Zip		e-mail	
You check e-mail:	Daily / Weekly / Monthly	Do you permit communication via e-mail?			Yes / No
SSN	- -	Employed	Full-Time / Part-Time / Unemployed / Homemaker		
Marital Status	Single / Married / Divorced /Separated	School	Full-Time / Part-Time / N/A		
Referred By		Employer/School			

II. Insurance or Responsible Party Payment Information.

Please complete if the patient is not the primarily insured or if someone other than Patient will be partially or fully responsible for payment for services provided.

First Name		MI		Last Name	
DOB		Home Phone		Cell	
Address				City	
State		Zip		e-mail	
SSN	- -	Employed	Full-Time / Part-Time / Unemployed / Homemaker		
Marital Status	Single / Married / Divorced /Separated				
Relationship to Patient	Spouse / Child / Other:				

III. formation about Insurance.

Please complete if insurance will be used.

Insurance Company					
Address				City	
State		Zip		Tel: Claims	
Tel: Precertification				Fax	
ID Number		Group Number			
Group Name		Co-Pay Terms			
Deductible		How much of the deductible is satisfied?			
Authorization Number from insurance		Number of sessions authorized			

Name of Patient: _____

Signature of Patient: _____ Date: _____

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Patient Name: _____ Date: _____

Thank you very much, in advance, for taking the time out to complete this questionnaire **before coming into our initial session**. It was designed to optimize the use of our time during the session. If you feel that you will not able to do justice to any of the questions stated below, please make a note of that and bring it to my attention during the session. I look forward to meeting you.

I. Reasons for Seeking Therapy. Please estimate your distress on the following scale:
0: None 1-2: Mild 3-5: Moderate 6-8: Severe

Sleep/appetite		Work issues		Panic attacks		Fear of flying, driving, claustrophobia, heights, medical, contracting illness, etc.	
Depression		Life issues		Social anxiety		Excessive / uncontrollable worrying	
Hopelessness		Sexual issues		Trauma		Obsessions, compulsions, rituals	
Mood swings		Grief/Loss		Anger		Relationship, marital, premarital	
Other (Please specify):							

How much has the above affected your functioning in various areas on the following scale: **0: None 1-2: Mild 3-5: Moderate 6-8: Severe**	Work / school: 0 1 2 3 4 5 6 7 8
	Marriage: 0 1 2 3 4 5 6 7 8
	Social: 0 1 2 3 4 5 6 7 8
	Health: 0 1 2 3 4 5 6 7 8
	Happiness: 0 1 2 3 4 5 6 7 8

IV. Anxiety and Depression History: Please list all significant episodes from **childhood on**. If therapy was received, please indicate with a **"T"**, if medications were prescribed please indicate with an **"M"**, if hospitalized please indicate with an **"H"**

ANXIETY			**DEPRESSION**		
Date Started	Date Ended	Therapy/Meds/ Hospitalization	Date Started	Date Ended	Therapy/Meds/ Hospitalization
		T/M/H			T/M/H
		T/M/H			T/M/H
		T/M/H			T/M/H
		T/M/H			T/M/H
		T/M/H			T/M/H
		T/M/H			T/M/H

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V. Past and Current Psychotherapy in Chronological Order

	Therapist 1	Therapist 2	Therapist 3
Name			
Date Started			
Date Stopped			
Reason Started			
Reason Stopped			

VI. Medical Information: Physicians

	Physician 1	Physician 2	Physician 3
Name			
Address			
Phone			
Fax			
Title			
Specialty			
Who is your Primary Care Physician			
Who is prescribing your medications			
Would you permit us to coordinate care with above physicians			Yes / No

V. Medical Information: Medical Condition

Date of Last Physical	
Summary of Results	
Medical Conditions	
Please describe any allergies to any environmental allergens or medications	

VII. Medications (Please **chronologically** list mental health related medications, **current and past**)

Medications	Dosage	Indication	Date Started	Date Ended	Reason Stopped

VIII. Life History:

What would best describe your adolescence (ages 12-19)?	
What would best describe your childhood (ages 0-12)?	

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Please reflect back as far as you can to recollect the positive and negative events that you consider significant that have happened in your life so far. Then list them in the table below in chronological order.

Started		Ended		Description of Event
Date	Age	Date	Age	

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VIII. Family History:

Your Marital History		
Please state the year you met your spouse and the year you were married		
If you are currently married	Year you met your spouse	
	Year you were married	
	Children and their ages	
Please describe briefly how you would characterize your current marriage		
If your current marriage is not your first marriage for each of your prior marriages please state the year you were married, the year the marriage ended, and the number of children from that marriage		

Your Parents			
		Mother	Father
Current age if alive			
If deceased, what was the age, year, and cause of death?	Age		
	Year		
	Cause		
Mental health conditions during lifetime: Please indicate any history of depression, anxiety, alcohol abuse or other drug abuse or psychosis.			
Physical conditions: Please indicate any significant chronic or current physical condition.			
Your parent's siblings: Please mention the number of siblings and any significant mental or physical condition. If deceased, please also mention year and cause of death and year of death.			
If your parents are still together how long have they been married?			
If your parents are not currently together, which year and after how many years of marriage was the marriage terminated? How old were you then?			
How would you describe your parents' marriage?			

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Your Siblings			
		Sibling One (oldest)	Sibling Two
Gender			
Current age if alive			
If deceased, what was the age, year, and cause of death?	Age		
	Year		
	Cause		
Mental health conditions during lifetime: Please indicate any history of depression, anxiety, alcohol abuse or other drug abuse or psychosis.			
Physical conditions: Please indicate any significant chronic or current physical condition.			

Your Siblings (Continued)			
		Sibling Three (oldest)	Sibling Four
Gender			
Current age if alive			
If deceased, what was the age, year, and cause of death?	Age		
	Year		
	Cause		
Mental health conditions during lifetime: Please indicate any history of depression, anxiety, alcohol abuse or other drug abuse or psychosis.			
Physical conditions: Please indicate any significant chronic or current physical condition.			

Your Mother's Parents			
		Mother	Father
Current age if alive			
If deceased, what was the age, year, and cause of death?	Age		
	Year		
	Cause		
Mental health conditions during lifetime: Please indicate any history of depression, anxiety, alcohol abuse or other drug abuse or psychosis.			
Physical conditions: Please indicate any significant chronic or current physical condition.			

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Your Father's Parents			
		Mother	Father
Current age if alive			
If deceased, what was the age, year, and cause of death?	Age		
	Year		
	Cause		
Mental health conditions during lifetime: Please indicate any history of depression, anxiety, alcohol abuse or other drug abuse or psychosis.			
Physical conditions: Please indicate any significant chronic or current physical condition.			

IX. If stress in any of the following domains is contributing significantly to the reasons you are seeking therapy, please rate the level of stress on a scale of zero to 10 with 10 being maximum stress. Please also briefly summarize the stressor.

	Rating (1 - 10)	Brief description of the stressor
Finances		
Health of significant others		
Legal matters		
Loss of loved one		
Own health		
Social		
Work/ School		

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IX. Person to Contact in an Emergency

First Name		MI		Last Name	
Address				City	
State		Zip		e-mail	
Cell		Home Phone		Work Phone	
Patient Relationship to Contact Person					

Please summarize the circumstances that led you to decide to seek therapy?

What are the three outcomes that you would like to achieve by the end of therapy?	
1	
2	
3	

X. Release of Information and Assignment of Benefits

1. I hereby assign to LifeQual LLC all benefits for services provided at LifeQual LLC.
2. I understand that it is our responsibility to contact our insurance company in a timely manner to obtain all authorizations necessary and to ensure payment of claims to LifeQual LLC.
3. I understand that we are financially responsible for all charges not paid by insurance.
4. I understand that we are fully responsible for payment of the Cancellation Fees as agreed in the **Consent to Treatment.**
5. I hereby authorize LifeQual LLC to release any information necessary to secure payment. We understand that my failure to pay will result in referral of the patient's account to a collection agency.

Signature of Patient: _____ Date: _____

Party responsible for payment if different from patient:

Full Name: _____ Signature: _____ Date: _____

THANK YOU FOR YOUR PATIENCE AND EFFORT. WE LOOK FORWARD TO SEEING YOU.

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CONSENT TO TREATMENT

This page contains information that will answer some important questions concerning my practice. Should you have additional questions after reading this statement, or indeed personal doubts, concerns, discomforts of any sort, I strongly urge you to discuss them with me at any time. Free and open communication between us in an atmosphere where you can feel safe is an important component of my psychotherapy practice.

Professional Credentials of Dr. Vijay Shankar:
I obtained my doctorate in 1996 from the School of Professional Psychology at Pacific University, Forest Grove. I have been with The Anxiety Disorders Clinic since 1996. Prior to that I worked at The Psychological Service Center of Pacific University, Tualatin Valley Mental Health, and Delaunay Family of Services. Since January 1, 2002, I have been a director of LifeQual LLC, a company dedicated to improving quality of living through health and wellness. I work with adults and adolescents and conduct both individual and group therapy. I also have two MBA degrees, one in finance and another in marketing and 15 years of experience working in the corporate business world.

Communication:
The owners of LifeQual LLC consist of myself, Anne B. Shankar, Licensed Clinical Social Worker. All those who are working for LifeQual LLC, will be bound by the terms of confidentiality outlined below.

Protecting your Confidentiality:
Both Federal and State confidentiality laws protect the work in my office. What that means is that information about you will not be released to anyone without your written permission. However, there are exceptions and I would like to explain these to you so that you are clear about what they are:

1. It is legally required of me that I act so as to prevent physical harm to yourself or others when there is "clear and imminent" danger of that happening.
2. In the case of a medical emergency, I may be forced to give medical and/or other information about you.
3. If I suspect that a patient is the victim, the perpetrator, or the observer of neglect, or of physical, emotional or sexual abuse of children, the disabled or the elderly, I will report this to the appropriate state agency, and involve the patient and appropriate family members whenever possible.
4. If insurance carriers are making part or all of your payments, I may have to release clinical information regarding you to them as required for payment or review of your claim.
5. I may have to release your records when ordered to do so by court subpoena. However, I will discuss details of privilege with you beforehand and request a written release from you if I judge this to be in your best interest. You should know that psychologists' privilege extends to both criminal and civil proceedings.
6. If your therapy is court ordered, or if I have been employed by an attorney or an agency to obtain information from you to provide an expert opinion, the patient/therapist confidentiality privilege does not apply.
7. When you raise the course of treatment or your mental state as an issue in a legal action, I can be forced to provide confidential information.
8. If you involve me in a conspiracy to commit a crime or to escape prosecution, confidentiality is not in effect.

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You should also be aware that there are other situations in which clinical and administrative reasons necessitate the sharing of information with others. All involved in such situations are bound by the same ethical and legal responsibilities to protect your confidentiality. These include:

1. When the primary patient is a minor, I expect the child's parents or legal guardian will respect the child's right to a confidential therapeutic relationship with me. I will divulge information to the parents or legal guardian against the child's wishes if required by law, or whenever I feel that failure to do so would not be in the child's best interests.
2. When conducting couples or family therapy if one family member reveals information to me about another family member who is also involved in the therapy but not present at that session, I would make a professional judgment about whether to disclose that information to the other person involved. Any patient may express the wish not to have certain disclosures shared, but the final decision must be left to me.
3. All those that work for me in an administrative capacity such as to type reports, manage files, mail invoices, liaise with insurance companies, and so on, will have access to all of your records.
4. On occasion, in order to provide you with a high level of care, I may decide to consult other appropriate and qualified professionals. In such cases information will be shared only either with your written consent or by suppressing all identifying information that is related to you.
5. In the event of my death or disability, your records will be turned over to another therapist and his or her staff. They will thus have access to your records.
6. In some cases, unpaid accounts may be turned over to a collection agency or attorney. This means that the collection agency or attorney will know that you are a patient in my office. Other administrative information may also be turned over to them.
7. Please also note that a fax machine may be used to transmit any of the above information.

Process, Risks and Benefits of Psychotherapy:

1. I believe that psychotherapy is a process in which we work together as a team. That work is better facilitated the more I understand you, the circumstances that brought you in, and the particular goals and objectives that you would like to achieve in therapy.
2. It is important for you to bear in mind that such success is not always possible. Please be aware that there may be times when you feel worse rather than better. Usually this is because issues and feelings may surface that you may not have confronted before. I believe that it is useful to know this and may help you in your commitment to the psychotherapy process.
3. I am fully committed to help you achieve your goals and objectives. If at any point I feel that I will not be able to fulfill that commitment, for whatever reason, I will discuss the situation with you and determine what the next appropriate steps should be.

Appointments:

Sessions **average 45 minutes in length**. However, please note that some sessions may be longer and others may be shorter, depending on the particular circumstances of the session.

Fees:

1. The per-session fee for the initial assessment and evaluation sessions is **$250.00**. Usually only one session is needed for the assessment and evaluation. However, in more complex cases more sessions may be needed. The fee per therapy session is **$180.00**.

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2. If any assessment, evaluation or therapy session goes beyond 60 minutes, you will be charged a prorated amount for each 15-minute segment past the 60-minute time limit.
3. These same prorated fees will also be charged to you for time I spend on your behalf, either in person, by telephone, or in providing written information, while interacting with attorneys, school personnel, counselors and physicians, or by appearing at hearings, staffing's, screenings, and so forth. If you have any questions about estimated costs or payment, please discuss them with me.

Payment for Session:

1. Since the nature of psychotherapy is such, the end of the session may not be conducive to dealing with payments. So please make all payments at the beginning of the session.
2. If you are covered by insurance, we will bill your insurance company on your behalf and the amount due from you for each session will be limited to your share of the session fees.
3. Payments may be made by cash, check or credit card. If payments are to be made by credit card, your account will be charged only once on the last day of the month.

Billing Statements:

1. If you have been paying your share of the payment at each session, then barring unforeseen adjustments that need to be made, there will be no personal balance due from you at the end of the month.
2. If you have opted to pay by credit card or have not been able to pay your share of the payment at the session, then the balance due from you will appear in your account as the "Client amount due". The term "Client amount due" is defined here to mean payments due from you or private parties (other than insurance companies) who have undertaken to be responsible to pay on your behalf. It does not extend to payments that are due from your insurance company for services provided to you but does extend to all other payments due from you including payment for materials bought from me, cancellation fees (please see below) etc. The statement you receive will identify the "Client amount due".
3. If there is a "Client amount due" as of the end of any calendar month, then it is our policy to charge your credit card for the amount of the "Client amount due" on the last day of that month. You will receive a statement detailing the charges within 15 days of the charge. In order for us to be able to do this we require you or the party responsible for making payments on your behalf, to complete the VISA/MASTERCARD AUTHORIZATION FORM that is enclosed in this package. If this is not possible for any reason, please let me know before therapy can proceed.
4. Please note that, in extreme cases and despite our best efforts, if you do not pay as agreed, your account may be turned over to an attorney or a collection agency for collection and you will be held responsible for any legal or collection costs incurred.

Cancellation Policy:

1. Please note that once a session has been scheduled, other patients' requests to be seen during that time will be denied. In that sense, it is a time slot that you have reserved that no one else will have access to. As a courtesy to those who may have wanted to come in to see me at that time, please try not to cancel any scheduled session. This is an extremely important part of my therapy practice.
2. If you must cancel, a **three-day notice** period is required. Any cancellations or changes in schedule made later than three days prior to the scheduled session will be charged a $45 cancellation fee. The cancellation fee will be due from you as insurance companies will not cover pay for any cancelled session.

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3. I will usually wait 30 minutes past the appointed time. After that I will consider the session as cancelled.

Weather or Other Emergencies:
In some cases, I may have to cancel sessions because of weather conditions or other personal or clinic related emergencies. In such cases I will make every effort to alert you of the situation as much in advance as possible. However, in the case of obvious emergencies such as weather, to be on the safe side, you may want to call my office before leaving for your session.

Crisis Intervention Plan
A crisis is defined as suicidal and/or life-threatening behaviors or gestures, and/or putting others at risk of harm. If you believe you are at risk of self or other harm, please take the following steps to decrease the risk and intervene in a safe manner:

1. Call Dr. Vijay Shankar's office at (503) 531-9355.
2. If you do not hear back from Dr. Shankar and believe that you are still at risk, please call:

Multnomah County	(503) 988 - 4888	**Washington County:**	(503) 291 – 9111
Clackamas County: Daytime:	(503) 655 - 8585	**Clackamas County, after hours:**	(503) 655 – 8724
Vancouver: From Portland:	(360) 696 - 9560	**Clark County:**	(360) 737 - 1399

Agreement:
I have read and agree to abide by the provisions of the above policy statement. I agree that if I have any questions at anytime I will discuss them with Dr. Shankar. My signature below indicates my agreement to enter into a therapeutic relationship with Dr. Shankar under the conditions specified and that if I fail to comply with these policies, he may discontinue providing psychological services.

_____ _____
Signature of patient Date:

_____ _____
Name and Signature of parent, guardian/legal representative if patient is a minor Date:

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Anne B. Shankar, MSQ, LCSQ Licensed Clinical Social Worker

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and LifeQual LLC. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions. By signing this form, you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form. If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you. In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from us. If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish. After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

By signing below, you confirm that you have received a copy of both, the short version of the NPP as well as a copy of the longer version. The effective date of both versions is April 14, 2003.

_____ _____
Signature of patient or his or her personal representative Date

_____
Relationship to the patient

_____
Printed name of patient or personal representative

_____
Description of personal representative's authority

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Authorization to Exchange Information

I authorize LifeQual LLC to exchange information regarding _____ with
Patient's Name

_____
Name of Individual/Institution that you are giving LifeQual LLC authorization to talk to

_____
Their Address City State Zip

_____
Their Phone Number

The information to be exchanged includes:

Current Progress Records _____
Medical Records _____
Results of Educational Testing _____
Results of Psychological Testing _____
Treatment Records Including Treatment Plan _____
Other, please specify: _____

I may revoke this consent at any time. Unless expressly revoked earlier, this consent will expire one year from the date of signing, or, upon termination of therapy by the joint consent of the service provider treating the patient at LifeQual LLC and the patient, if that occurs later.

_____ _____
Signature of patient Date:

_____ _____
Name and Signature of parent, guardian/legal representative if patient is a minor Date:

_____
Client Address City State Zip

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CREDIT CARD AUTHORIZATION FORM

Vijay Shankar, MBA, Psy. D Licensed Psychologist Anne B. Shankar, MSQ, LCSQ Licensed Clinical Social Worker
In order to be able to charge your credit card for balances due (please refer to the form "CONSENT TO TREATMENT" section "Billing Statements"), please complete this form and return it to me. As with all of your information, this information will be kept secure and in compliance with Federal HIPAA standards.

Name of client: _____

Name as it appears on card (Card Holder) _____

Credit card billing address: _____

City_____State_____Zip_____

Home Phone # of card holder _____

Credit card (please circle one): Visa / MasterCard / Discover

Card number: _____ Expiration date: _____

Three-digit security code on the back of the card _____

I, _____ (**First and Last Name of Cardholder),** hereby authorize Vijay Shankar, Psy.D. to charge the above credit card for any outstanding fees due for services incurred. I understand that this authorization is also an acknowledgment that I have read and understand the terms and conditions of this payment as per the **CONSENT TO TREATMENT** form given to me at the outset of therapy.

_____ _____
Authorized signature of card holder Date

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Vijay Shankar, MBA, Psy. D Licensed Psychologist
Anne B. Shankar, MSQ, LCSQ Licensed Clinical Social Worker

1975 NW167th Place, Beaverton, OR 97006

1. On NW Cornell Road, if heading towards Hillsboro turn right at 167th place, if heading towards Portland turn left on 167th place.
2. The office building is directly behind The Mongolian Grill and left of Legacy Medical Group-Cornell.
3. Enter by the double doors below the number 100.
4. If door is locked please ring the bell and I will come out to get you.

4000 Kruse Way Pl, BLDG 2, Lake Oswego, OR 97035

1. From 217 South or Route 5
2. Take Kruse Way toward Lake Oswego for 1.2 Miles
3. Turn left onto Daniel Way.
4. Take the 1st right onto Kruse Way Pl.
5. BLDG 2 is on the left.

1962 NW Kearney, Suite 303, Portland, OR 97209

1. Head north on 21st
2. The streets are arranged alphabetically
3. Turn right on Kearney
4. The streets will decrease numerically. Our office building will be on the right side between 20th and 19th.

5. The building is a tall beige Victorian building. Our office is on the 3rd floor. Parking is usually available around the building and on the street.