VIJAY SHANKAR, MBA, Psy.D., Licensed Psychologist
ANNE B. SHANKAR, M.Sc.,MSW, Licensed Clinical Social Worker

PATIENT INFORMATION
Administrative

I. Information about Patient

First Name		MI		Last Name			
Address				City			
State		Zip		Birth Date			
Home Phone				Work Phone			
Cell Phone				e-mail			
You check e-mail	Daily / weekly /monthly			Do you permit communication by e-mail		Yes / No	
Social Security No.				Employed	Full-Time / Part-Time / Homemaker		
Marital Status	Single / Married /Divorced / Separated			School	Full-Time / Part-Time / Not studying		
Referred By				Employer/School			

II. Information about Primary Insured or Party Responsible for payment.

Please complete if Patient is not the primary insured or if someone other than Patient will be partially or fully responsible for payment for services provided by Dr. Vijay Shankar.

First Name		MI		Last Name			
Address				City			
State		Zip		Birth Date			
Home Phone				Work Phone			
Cell Phone				e-mail			
Social Security No.				Employed	Full-Time / Part-Time / Homemaker		
Marital Status	Single / Married /Divorced / Separated			Employer			
Patient Relationship to Primary Insured				Spouse / Child / Other:			

III. Information about Insurance.

Please complete if insurance will be used.

Insurance Company							
Address				City			
State		Zip Code		Tel: Claims			
Tel: Precertification				Fax			
ID Number				Group Number			
Group Name				Copay terms			
Deductible		How Much of Deductible Satisfied					
Authorization Number from insurance				No. of sessions authorized			

Name of Patient: _____

Signature of Patient: _____ Date: _____

CONSENT TO TREATMENT

The purpose of this document is to inform you of your rights and responsibilities under the law. Should you have additional questions after reading this statement, or personal doubts, concerns, discomforts or questions of any sort, I strongly urge you to discuss them at any time. I fully believe that free and open communication between us in an atmosphere where you can feel safe is an important component of the psychotherapy experience.

COMMUNICATIONS:

Since January 1, 2002, I have been a director of LifeQual LLC, a company dedicated to improving quality of living through health and wellness. Vijay is the co-owner as well as a Director of LifeQual LLC. In addition to the two of us, our staff 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) If I have reason to suspect that a client is the victim, the perpetrator, or the observer of neglect, or of physical, emotional or sexual abuse of children, disabled or the elderly, I will report this to the appropriate state agency, involving client and appropriate family members whenever possible.

3) In the case of a medical emergency, I may be forced to give medical and/or other information about you.

4) I may have to release your records when ordered to do so by court subpoena.

5) 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.

6) 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.

7) If you involve me in a conspiracy to commit a crime or to escape prosecution, confidentiality is not in effect.

8) 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.

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

1) 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.
2) Those who work for me in an administrative capacity such as to type reports, manage files, mail invoices, interact with insurance companies, and so on, will have access to your records.
3) 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.
4) 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.
5) 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 client in my office. Fees, addresses, phone numbers and other administrative information may also be turned over to them.

Please also note that in any of the situations cited above a fax machine may be used to transmit information.

CLIENT'S RIGHTS:

As a client, you have certain rights which include:

1) To expect that a licensee has met the minimal qualifications of training and experience required by state law;
2) To examine public records maintained by the Board which contain the credentials of a licensee;
3) To obtain a copy of the Code of Ethics;
4) To report complaints to the Board;
5) To be informed of the cost of professional services before receiving the services;
6) To privacy as defined by rule and law;
7) To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

RISKS AND BENEFITS OF PSYCHOTHERAPY:

A number of factors play a role for successful outcome in psychotherapy. It is important for you to bear in mind that such success is not always possible or guaranteed. Likewise, you should know 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. The expectation from psychotherapy is that with both of us carrying out our respective roles to the fullest possible, conditions will be created for you to achieve the goals and objectives that prompted you to seek therapy.

Successful therapy requires an acceptance of responsibility for the behavior, a commitment to change, and a positive working alliance between the client and the therapist. This further includes attending sessions regularly and promptly.

FEE AGREEMENT

The per session fee for the initial assessment is **$250.00.** Usually only one session is needed for the assessment. However, in more complex cases more sessions may be needed. The fee per therapy session thereafter is **$180.00**. Sessions average 50 to 60 minutes in length.

1. 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.
2. 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, staffings, 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.

Please note that it is your responsibility to obtain preauthorization from your insurance company for my services prior to the start of therapy. Failure to do so may result in the insurance company denying responsibility for payment for services provided.

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. 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.

CANCELATION 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.
2. If you must cancel, a 24 hour notice period is required and there will be a $50.00 late cancellation fee charge. There will be no charge for cancellations given 24 hours in advance.
3. The fee of $50.00 is charged for missed appointments not cancelled 24 hours before the scheduled start of your session unless the missed appointment can be rescheduled within the same week. The cancellation fee will be due from you as insurance companies will not pay for any cancelled session.
4. Please initial here if you understand and will abide by the above cancellation policy._____

WEATHER OR OTHER EMERGENCIES:

1. 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, you may want to call my office before leaving for your session to confirm your appointment.

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 Anne Shankar's office at (503) 531 9355 or my cell at 503-358-2499.
2. If you do not hear back from Anne 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 any time I will discuss them with Anne Shankar. My signature below indicates my agreement to enter into a therapeutic relationship with Anne Shankar under the conditions specified and that if I fail to comply with these policies, she may discontinue providing psychological services.

Signature of patient Date

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

Name of Patient: _____ **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

II. 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

III. Past and Current Psychotherapy in Chronological Order

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

IV. Medical Information: Physicians

	Physician 1	Physician 2	Physician 3
Name			
Address			
Tel			
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	None, Inner ear problems, mitro valve prolapse, hyperthyroidism, hypoglycemia		
Other:			
Please describe any allergies to any environmental allergens or medications:			

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

Medications	Dosage	Purpose	Date Started	Date Ended	Reason Stopped

VII. Life History:

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

Please reflect back and recollect the events that you consider significant that have happened in your life so far. Please go back as far as you can remember and be sure to include both positive and negative events. Then list them in the table below in chronological order. If further space is needed please add.

Started		**Ended**		**Description of Event.**
Date	Age	Date	Age	

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 <u>not your first marriage</u> 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 parent's marriage?			

Your Siblings		Sibling 1 (oldest)	Sibling 2
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 3	Sibling 4
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.			

Your Father's Parents		Mother	Father
Current Age			
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.

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

X. Person to Contact in an Emergency

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

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

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

XIII. Release of Information and Assignment of Benefits

1) We hereby assign to LifeQual LLC all benefits for services provided by the service providers at LifeQual LLC.
2) We 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) We understand that we are financially responsible for all charges not paid by insurance.
4) We understand that we are fully responsible for payment of the Cancellation Fees as agreed in the CONSENT TO TREATMENT.
5) We hereby authorize LifeQual LLC to release any information necessary to secure payment. We understand that our 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.

Authorization to Exchange Information

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

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

_____
Their Address

_____
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

Signature of parent, guardian or legal representative if patient is a minor (circle one) Date

Client's Address City State Zip

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

Printed name of patient or personal representative Relationship to the patient

Description of personal representative's authority

CREDIT CARD AUTHORIZATION FORM

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 _____ (Usually last three digits)

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

Directions to Anne Shankar's Offices

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.

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.