Allison Gullo, MD
General and Geriatric Psychiatry
Phone: (503) 512-1218

10001 SE Sunnyside Rd. Suite 100
Clackamas, OR 97015
Fax: (503)-512-1220

Welcome!

Your patient consultation appointment is scheduled for:

_____

Arrive 10-15 minutes early.

- Complete the enclosed paperwork and bring to your appointment along with your insurance card.
- Be prepared to pay your co-payment and/or co-insurance prior to your appointment.

We believe the more you know about the practice of Allison Gullo, MD and Willamette Pain and Spine Center (WPSC) the better we can partner with you and your other care providers to make a difference. Please take a few minutes to read and become familiar with the following information:

Clinic Hours: Monday – Thursday, 8:00am – 4:30pm Friday, 8:00 – 12:00

Appointments: Please arrive 10-15 minutes before your scheduled appointment time for your initial consultation appointment to allow for registration. Late arrivals or those needing additional time for registration may be rescheduled. Arriving on time allows her to stay on schedule so that all patients are treated in a timely manner. **If you need to cancel your appointment, please call 503-512-1218 at least 24 hours prior to your scheduled appointment time to avoid a $50 late cancellation fee.**

Telephone Calls: Dr. Gullo attempts to be thorough and complete during your visit. She will rarely be interrupted by phone calls or other matters during your visit. Patients are asked to respect one another's time by holding questions for scheduled office visits. You are encouraged to write your questions down so they can be addressed during your scheduled appointment. If your questions cannot wait, you may call (503) 512-1218 and leave a message. Non-urgent matters will be addressed no later than the end of the next business day. Please do not leave duplicate messages unless you have not heard back from us within 48 hours.

Emergencies: If you feel you are experiencing an emergent situation, please go directly to the nearest emergency room or urgent care facility. The provider at this facility will call and communicate with Dr. Gullo.

Forms: Most form completions require discussion between the provider and patient. Therefore, if you have a form related to your care with Dr. Gullo that needs to be completed, please call (503) 512-1218 so an appointment can be scheduled.

Prescriptions: The State of Oregon requires providers to inform patients of the material risks related to the use of narcotic medicines. This information is in the provider agreement you will receive and be asked to sign at your consultation appointment. Prescription refills will only be given at your scheduled appointments.

Test Results: All test results are reviewed by Dr. Gullo when received. Results will be discussed with you at your scheduled follow up visit. Urgent findings will be addressed sooner, as appropriate.

Code of Conduct: Every staff member at WPSC conducts themselves with respect toward patients, family members, referring physicians and staff. We expect behavior that respects the rights of other patients and our office staff. Unacceptable behavior includes the following and will not be tolerated:

- Excessive noise which is obtrusive to others
- Use of language, gestures or actions that are threatening, abusive, obscene or aggressive
- Offensive remarks of a racial, sexual or perverse nature
- Damage to property & theft
- Inappropriate behavior involving alcohol/substance misuse

YOUR APPOINTMENT IS SCHEDULED AT THIS LOCATION:
Sunnyside Plaza
10001 SE Sunnyside Rd. Suite 100
Clackamas OR 97015

Directions:

From Interstate 205, take exit 14 Sunnybrook/Sunnyside Exit. Proceed to Sunnyside Rd. and turn east (the opposite direction of the Clackamas Town Center.) Drive 1 block to the light at Stevens Rd. and turn left. Take immediate right into the parking lot and proceed north to the back of the parking lot to our building.

Allison Gullo, MD
Psychiatric Intake Form

(All information on this form is strictly confidential)

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. If assistance was required in filling this form out, please indicate on form with name and relationship.

Name: _____ Date: _____
Date of Birth: _____
Primary Care Physician: _____
Current Therapist/Counselor: _____
Therapist's Phone Number: _____

What are the problem(s) you are seeking help for?

1. _____
2. _____
3. _____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

____Depressed mood	____Racing thoughts	____Excessive worry	
____Unable to enjoy activities	____Impulsivity	____Anxiety attacks	
____Sleep pattern disturbance	____Increased risky behavior	____Avoidance	
____Loss of interest	____Increased libido	____Hallucinations	
____Concentration/forgetfulness	____Decreased need for sleep	____Suspiciousness	
____Change in appetite	____Excessive Energy	____Excessive Guilt	____Increased Irritability
____Fatique	____Crying spells	____Decreased libido	____Other_____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live?	___Yes	___No
Do you currently feel that you don't want to live?	___Yes	___No
Have you ever tried to kill or harm yourself before?	___Yes	___No

Memory Questions

Do you feel you have problems with memory?	___Yes	___No
If yes, please describe_____		
Does anyone in your family carry a diagnosis of dementia?	___Yes	___No

Your Medical History

Allergies_____
Current Weight _____ Height _____

List ALL current medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dose	Estimated Start Date

Current over-the-counter medications or supplements:

Current Medical Problems:

Past medical problems, nonpsychiatric hospitalization or surgeries:

Have you ever had an EKG? ☐ Yes ☐ No If yes, when_____
Was the EKG ☐Normal ☐ Abnormal or ☐Unknown?

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ☐ Yes ☐ No. Are you planning to get pregnant in the near future? ☐ Yes ☐ No
Birth Control method _____
How many times have you been pregnant? _____How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with me? ☐ Yes ☐ No
Date and place of last physical Exam:_____

Personal and Family Medical History:

	You	Family	Which Family Member
Thyroid Disease	☐	☐	_____
Anemia	☐	☐	_____
Liver Disease	☐	☐	_____
Chronic Fatigue	☐	☐	_____
Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____
Asthma/respiratory problems	☐	☐	_____
Stomach or intestinal problems	☐	☐	_____
Cancer (type)	☐	☐	_____
Fibromyalgia	☐	☐	_____
Heart Disease	☐	☐	_____
Epilepsy or seizures	☐	☐	_____
Chronic Pain	☐	☐	_____
High Cholesterol	☐	☐	_____
High Blood Pressure	☐	☐	_____
Head Trauma	☐	☐	_____
Liver Problems	☐	☐	_____

Is there any additional personal or family medical history? ☐ Yes ☐ No If yes, please explain:

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Is there any history of brain injury, being knocked unconscious, or seizures? If yes, please explain:

Past Psychiatric History

Outpatient treatment ☐ Yes ☐ No. If yes, Please describe when, by whom, and nature of treatment.

Reason Dates treated By whom

Psychiatric Hospitalization ☐ Yes ☐ No. If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate by place a check mark next to medication.

Antidepressants

☐ Prozac (fluoxetine) ☐ Zoloft (sertraline) ☐ Luvox (fluvoxamine)
☐ Paxil (paraxetine) ☐ Celexa (citalopram) ☐ Lexapro (escitalopram)
☐ Effexor (venlafaxine) ☐ Cymbalta (duloxetine) ☐ Wellbutrin (bupropion)
☐ Remeron (mirtazapine) ☐ Serzone (nefazodone) ☐ Anafranil (clomipramine)
☐ Pamelor (nortrptyline) ☐ Tofranil (imipramine) ☐ Elavil (amitriptyline) ☐ Other

Mood Stabilizers

☐ Tegretol (carbamazepine) ☐ Lithium ☐ Depakote (valproate)
☐ Lamictal (lamotrigine) ☐ Topamax (topiramate)
☐ Other_____

Antipsychotics/Mood Stabilizers

☐ Seroquel (queiapine) ☐ Zyprexa (olanzepine) ☐ Geodon (ziprasidone)
☐ Abilify (aripiprozole) ☐ Clozaril (clozapine) ☐ Haldol (haloperidol)
☐ Prolixin (fluphenazine) ☐ Other: _____

Sedative/Hypnotics

☐ Ambien (zolpidem) ☐ Sonata (zaleplon) ☐ Rozerem (ramelteon)
☐ Restoril (temazepam) ☐ Desyrel (trazadone) ☐ Other:_____

ADHD medications

☐ Adderall (amphetamine) ☐ Concerta (methylphenidate) ☐ Ritalin (methylphenidate)
☐ Strattera (atomoxetine) ☐ Other:_____

Antianxiety medications

☐ Xanax (alprazolam) ☐ Ativan (lorazepam) ☐ Klonopin (clonazepam)
☐ Valium (diazepam) ☐ Tranxene (cloazepate) ☐ Buspar (buspirone)

Family Psychiatric History:

Has anyone in your family been diagnosed with or treat for:

Bipolar Disorder: ☐ Yes ☐ No Schizophrenia ☐ Yes No

Depression: ☐ Yes ☐ No Post-traumatic stress ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No Alcohol abuse ☐ Yes ☐ No

Anger ☐ Yes ☐ No Other substance abuse ☐ Yes ☐ No

Suicide ☐ Yes ☐ No Violence ☐ Yes ☐ No

If yes, who had what problems?_____

Has any family member been treated with a psychiatric medication? ☐ Yes ☐ No. If yes, who was treated and what medications and how effective was the treatment?

_____

Substance Abuse:

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, for which substances?_____

If yes, where were you treated and when?

Any history of complicated withdrawal from substances including seizures or delirium tremens (DTs)? If yes, explain.

_____

Are you currently using any alcohol, recreational drugs, or misusing prescription medications? ☐ Yes ☐ No

If yes, please describe._____

Tobacco History:

Do you currently use any tobacco products such as cigarettes, cigars, pipes, or chewing tobacco? If yes, how much and how often._____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically, or by neglect? ☐ Yes ☐ No

Educational History:

What is your highest educational level or degree attained?_____

Occupational History:

Are you currently: ☐ Working ☐ not working by choice Unemployed ☐ Disabled ☐ Retired

What is/was your occupation?_____

Where do you work?_____

Have you ever served in the military?_____

If so, what branch and when?

_____

Honorable discharge ☐ Yes ☐ No Other type of discharge_____

Relationship History and Current Family:

Are you currently: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Partnered

How long?_____

If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long?_____

What is your spouse or significant other's occupation?_____

Describe your relationship with your spouse or significant other: _____

Have you had prior marriages? ☐ Yes ☐ No If so, how many?_____

How long?_____

Do you have children? ☐ Yes ☐ No If yes, list ages and gender

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Describe your relationship with your children:_____

Legal:

Have you ever been arrested? ☐ Yes ☐ No

Do you have any pending legal problems? ☐ Yes ☐ No

Is there anything else that you would like the provider to know?

Signature_____Date:_____

Emergency Contact: _____

Telephone #:_____

Reviewed by_____Date:_____

This portion only needs to be completed

Please check any of the illnesses you have now or have had in the past and please indicate how much it interferes with your activities at present.

Illness	Have or have had	Does not interfere at all	Intereferes a little	Interferes a great deal
Arthritis				
Glaumcoma or Cataracts				
Breathing problems: (shortness of breath)				
Asthma				
Bronchitis				
Emphysema				
High Blood Pressure				
Tuberculosis				
Diabetes				
Circulation trouble in arms & legs				
Anemia				
Bleeding Problems				
Thyroid Problems				
Cancer or Leukemia				
Digestive system Problems:				
Ulcers				
Heartburn				
Hiatal Hernia				
Collitis				
Diverticulitis				

Seizures				
Parkinson's Disease				
Constipation				
Urinary Problems:				
Wetness after coughing or sneezing				
Urgency				
Frequency				
Burning				
Prostate Problems				
Difficulty walking				
Dizziness				
Falling				
Broken bones				
Weight loss				
Unsteadiness				
List and other medical problems you have had which are not listed above:				

PATIENT REGISTRATION FORM

Primary Care Physician:	**Today's Date:**

PATIENT INFORMATION

Patient Name: Last First Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name? _____	(Former Name): _____	Age:	Date of Birth:	Gender: ❑ M ❑ F

Address:	Social Security #:	Home phone:
City:	State:	Zip:	Cell Phone:
Occupation:	Employer:	Work Phone:

RESPONSIBLE PARTY

Name: Last First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:

Address:	Social Security #:	Home phone:
City:	State:	Zip:	Cell Phone:
Occupation:	Employer:	Work Phone:

INSURANCE INFORMATION
(Please give your card to the receptionist)

Primary Insurance:	Insurance Phone No.:	
Insurance Address, City, State, Zip:	ID #:	Group #:

Subscriber Name: Last First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:
Employer:	Work Phone:		

Secondary Insurance (if applicable):	Secondary Insurance Phone No.:	
Insurance Address, City, State, Zip:	ID #:	Group #:

Subscriber Name: Last First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:
Employer:	Work Phone:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician/clinic. I understand that I am financially responsible for any balance. I also authorize Allison Gullo, MD/Willamette Pain and Spine Center or the insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ Date: _____

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FINANCIAL POLICY

Thank you for choosing Allison Gullo, MD and Willamette Pain and Spine Center to assist you with your mental health care needs. We strive to provide you with the best care possible, and, in return, we ask that you assist us not only in monitoring your mental health care, but also by paying for our services in a responsible and timely manner.

The following is a statement of our financial policy. Our office requires that each patient read and sign a copy of this policy before we provide any treatment. Therefore, please read through this statement and feel free to ask us any questions you may have relating to our policy.

Acceptable Payment Methods:

We do not accept personal checks. We do not accept personal checks or American Express, other payments accepted, Cash, Visa, Discover and MasterCard.

Insurance: We will bill most (but not all) insurances as a courtesy to you. Our office accepts assignment of benefits from many insurance companies. However, we **do not** accept all benefit programs. Therefore, please inquire as to whether or not your insurance company is accepted by this office when taking into account what method of payment you will want to use.

We require that your co-payment, co-insurance and/or deductible be paid at the time of service. In the event that we do not accept assignment of benefits from a particular insurance company, we require that you pay your bill in full at the time of each visit.

Your bill is your responsibility. If your insurance company or other benefit program doesn't cover the entire bill, it's your responsibility to pay the balance. We expect payment in full within 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Usual and Customary Rates: We are dedicated to providing the best treatment for our patients and we charge what is usual and customary for our area of the country. You are responsible for payment regardless of any insurance company's (or any other benefit programs) arbitrary determination of what are usual and customary rates.

Missed Appointments: You will be charged for missed appointments; follow-up appointments that are not cancelled at least 24-hours in advance, **is $25.00**. A New Patient Appointment or Procedure that is not cancelled or missed with less than 24-hours advance notice will be **charged $50.00**. **If you are late 10 minutes or more for your appointment you will be rescheduled and charged a $25 missed appointment fee. Three or more missed appointments are grounds for termination of the patient/provider relationship.**

I certify that I have read and understand the "Financial Policy" and agree to all terms and conditions as stated above. I understand it is my sole responsibility to verify my medical coverage with the insurance company, MHO or PPO, Medicare/Medicaid or other benefits programs and that I am ultimately responsible for payment in full for any outstanding balances incurred.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

Allison Gullo, MD

Consent for Treatment and Payment Agreement

I hereby authorize **Allison Gullo, MD and Willamette Pain and Spine Center, PC** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations.

Treatment includes, but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory test, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes, but is not limited to: the authorization of payment directly to **Allison Gullo, MD and/or Willamette Pain and Spine Center, PC** of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee and understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include, but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor, we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Allison Gullo, MD and Willamette Pain and Spine Center, PC all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient Initials:_____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Allison Gullo, MD and/or Willamette Pain and Spine Center, PC. Patient Initials:_____

I request this authorization also apply to all other insurance. Patient Initials:_____

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and other listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive information	Release info (please circle)		Allowed in exam room (please circle)	
_____	Y	N	Y	N
_____	Y	N	Y	N
_____	Y	N	Y	N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure.**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature_____

Date_____ Patient Date of Birth_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:Required By Law: **We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.**

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited

information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as

necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our Compliance Officer, Debra Kirk.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Angel Osipovich** at (503) 512-1222 or **aosipovich@willamettepain.com** for further information about the complaint process.

Allison Gullo, MD
General and Geriatric Psychiatry
Phone (503) 512-1218

10001 SE Sunnyside Rd., Ste 100
Clackamas, OR 97015
Fax (503) 512-1220

willamette PAIN & SPINE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of *Allison Gullo, MD and Willamette Pain and Spine Center's* Notice of Privacy Practices.

Name: _____ Date:_____

Signature: _____

I hereby acknowledge that I was offered and declined a copy of the Notice of Privacy Practice. I agree that Allison Gullo, MD and/or Willamette Pain & Spine Center made a good faith effort to provide me with this information. I understand I may request a copy of the Notice of Privacy Practices at any time and may also find it on the website at www.willamettepain.com; the medical office from which services are rendered.

Name: _____ Date: _____

Signature: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Other:

Name of Patient: _____

Allison Gullo, MD
General and Geriatric Psychiatry
Phone: (503) 512-1218

10001 SE Sunnyside Rd, #100
Clackamas, OR 97015
P: 503-512-1218
F: 503-512-1220

Federal guidelines require that we request the following information. Please complete the following questions:

Race:
_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ White
_____ Other Race
_____ Declined

Ethnicity:
____Argentinean
____Central American
____Columbian
____Costa Rican
____Cuban
____Dominican
____Hispanic or Latino
____Latin American
____Mexico
____Not Hispanic or Latino
____Puerto Rican
____Declined

Preferred Contact/Yearly Reminders Method:
_____ Cell Phone
_____ Home Phone
_____ Office Phone
_____ Mail
_____Email

**Patient Portal coming soon, please provide your email address to access your chart online. **

Email _____

COMMUNICATION RELEASE

I authorize Willamette Pain & Spine Center to share certain medical information with the person(s) named below:

Name:_____ Relation: _____ Phone:_____

Name:_____ Relation: _____ Phone:_____

This authorization will remain in effect while I am under the care of Willamette Pain & Spine Center. I understand that I can revoke this authorization at any time in writing.

☐ By checking this box, I have acknowledged that I wish to give consent to the individuals listed above to have access to my medical information. This includes mental health, drug and/or alcohol abuse and sexual content.

Print Patient Name _____ Date of Birth _____
Signature: _____ Today's Date _____