Kaizen Psychiatric Services
14845 SW Murray Scholls Dr, Ste 110 PMB 412
Beaverton, OR - 97007-9237

2025_Behavior Contract

2025 BEHAVIOR CONTRACT

Behavior Contract DATE SIGNED: *

This agreement is between the above patient and Kaizen Collective, its providers, and staff. We are committed to treating all patients with dignity and respect while providing the best possible care. To keep you healthy and safe and foster a mutually respectful relationship, we have the following expectations for all patients, care team members, support persons, and family members.

I will read and cooperate with the clinic policies and procedures, as listed on the Kaizen Psychiatric website, at the following link(s) https://www.kaizenpsychiatric.com/kaizen-practice-policies and https://www.kaizenpsychiatric.com/rights-responsibilities.

Communication is vital; it can break down when multiple supporters are involved in treatment. I agree to participate in my role of making communication more effective by doing the following: Provide a single point of contact for my or my patient's care team. Care teams may include case workers, therapists, other providers, resource parents, teachers, or other support persons. The single point of contact is responsible for conveying information to the other members of my team.

I understand that Kaizen Collective will only release records once to the designated point of contact that I have provided. I acknowledge their responsibility to share the released documents, given by Kaizen Collective and its members, with my care team.

I agree to contact the clinic 24 hours in advance if I cannot keep my appointment and will reschedule my appointment using the patient portal. Any cancellation within 24 hours is considered a no-show. Unless explicitly stated otherwise by the provider.

I understand that I may be discharged from the clinic for 3 missed appointments (no-show) or 3 cancelled appointments in the same 12 months. I understand that missing multiple appointments is dangerous for my well-being and impairs my recovery.

I understand that I will be warned via patient portal after I miss the second appointment or cancel within 24 hours. I understand that I will be discharged if there is another missed visit or late cancellation of an appointment in 6 months.

I understand that if I am discharged, the provider will give me 90 days of medication excluding controlled substances.
I understand the provider will give me 30 days of ADHD medicine and 60 days of pain medicine or anxiety

medicine.
It will be my responsibility to contact my insurance and request a list of providers in order to find a new prescriber.

I understand that my Provider has a medically dependant child and may need to cancel or reschedule an appointment with very little notice. If this occurs, I may be contacted by an office admin but it is my responsibility to reschedule the appointment. I understand that my provider will issue refills to bridge the time until the next available appointment. If a co-pay has been collected, it will be held until the next appointment.

When I request an appointment, I understand that it may be changed or cancelled depending on my Providers discretion.
I understand that I will be notified via portal about the change and that it is my responsibility to check the portal. Although the patient portal has been set to send an appointment reminder via text the day before my appointment, it is my responsibility to keep track of my appointments.

I understand it is my responsibility to check the patient portal to and complete the Pre-Visit Questionnaire and/or any screening questionnaire within 24 hours of the appointment. I understand that my appointment may be ended if I do not complete the requested Pre-Visit or screening questionnaires.
I agree to send a portal message to the office if I am confused about questionnaires or if the date/ time of my appointment no longer work for my schedule.
I understand that I can cancel and reschedule my own appointments prior to 24 hours before my appointment.

I will schedule my appointments based on my provider's recommendations.
I understand that I may not receive refills unless I have followed up appropriately with my provider.
I acknowledge that my provider may ask me to schedule an appointment before providing refills or that I am subject to receiving a smaller supply of medication that is sufficient to bridge the time until my next visit.
I understand that refills of controlled substances will not be provided until I have scheduled a follow up appointment.

I will appropriately use the patient portal to request refills, make appointments, change my pharmacy, update my contact information, and ask questions.

If I am having trouble logging in to telehealth or if it is more than 10 minutes after my appointment time and no one has contacted me I will text the office at (360) 836-0171.
If I am having trouble accessing or using using the patient portal, I will contact the office via text ((360) 836-0171), or email to: info@kaizenpsychiatric.com.

I will send necessary documents to the office in pdf form via the patient portal.

I agree to be cooperative and willing to see my provider in person if requested.
I understand that a yearly face to face, in-person meeting is required but that my provider may want to see me in-person more often.

I acknowledge that refill requests may take 3-5 days to be processed and sent to my pharmacy, and I agree to plan for this time frame. I acknowledge that the clinic will respond to me within 3-5 days, and I agree to check the appropriate patient portal for a response.

I understand that it is my responsibility to keep my medication safe from damage, theft or loss.
I understand that controlled substances will not be refilled early and that I may be required to file a police report if my medications are stolen.

If I need an early refill for travel (work or vacation), I agree to discuss it with my provider in advance. I understand that my provider may not be able to approve an early refill, and that my insurance may not pay for an early refill of medications.

I agree to seek care in an emergency room, use my county's crisis services, call 911, see my PCP, or be assessed at urgent care if my provider requests it to keep me safe.

If my provider feels that I cannot keep myself safe or if I do not follow my provider's directions, I acknowledge that my provider will contact the appropriate emergency services on my behalf.

I will comply with my treatment plan and recommendations, including lab work, imaging, referrals, therapy, and lifestyle changes. If I have questions or concerns about my treatment plan or recommendations on my treatment plan, I will discuss them with my provider during an appointment.

I understand that refusing or failing to follow my providers recommendations can be dangerous for my health and impairs my recovery.

I will only take medications prescribed to me according to the directions given by my provider. I will not take medications prescribed to others or share my prescribed medicines with others.

I will provide the office with my phone number, email address, mailing address, and correct insurance information within 14 days of any changes. If the patient can't update the office, a responsible party, point-of-contact, or the financial guarantor for the patient will need to notify the staff within 14 days.

I agree to notify the office as soon as possible if I have any significant or life-threatening health updates.
I agree to alert the office as soon as possible if another provider prescribes a new medicine, if I am under arrest, expelled or suspended, lose housing, or have any other significant life change.

I will treat staff with respect and dignity in person, on the phone, over email, through text, or on a telehealth visit. I will use a respectful tone of speech when interacting with staff.

I understand that I can be discharged if I choose to be rude, hurtful. racist, sexist, or use any other type of hate speech. This includes illustrations/ writing/ print on my clothing or headgear, my profile picture or screen name and anything visible in the background of a telehealth call. This applies to me and any family member or friend who appears with me or acts on my behalf.

I acknowledge that any family member or supporter who displays disruptive behavior during communication with me (patient) or disrupts any type of visit (in-person or via telehealth) will initially be alerted of Kaizen Collective's policy regarding such behaviors as well as the possible consequences of violating this policy. If this behavior continues, the family member will no longer be welcome to participate in the patient-provider team.

I understand that failure to pay my bill or co-pay in a timely manner may result in discharge from the clinic. If I am having trouble paying my bill or lose insurance, I will send a portal message and discuss the issue with my provider at our appointment.

Violations of the 2025 Behavior Contract

If the above expectations are violated, the provider will discuss the issue or episode with appropriate parties. Then, if appropriate, issue a "warning". If patient accumulates three warnings, the clinic may elect to terminate the patient-provider relationship. If this occurs, you will receive a letter via the pt portal and your email describing the next steps to take.

You or the patient has the right to discuss this contract with their provider, and contribute additional information in a respectful manner in writing if desired. Kaizen Collective will adhere to patient-provider termination procedures that include patient continuity of care protocols if it is decided to terminate patient-provider relationship.

An appeal regarding this behavior contract violation and clinic actions thereafter will be taken into consideration for violations that do not pose a threat to staff, patient, or other persons present when behavior occurred. This appeal will be heard by the clinic committee in place when the appeal is presented in writing by the patient or guardian. Appeals will not be considered for physical violence or threats of violence. An appeal does not guarantee the clinic will remove the "warning" from the patient's record. Kaizen Collective reserves the right to decide and enforce the outcome of any patient appeal.

My signature below indicates:

I have read Kaizen Collective's “Patient Rights and Responsibilities” policy and I understand where to find them on the Kaizen Collective website.

I have read and understand the above-listed behavioral expectations. I also understand that failure to meet these expectations may result in termination of the patient-provider relationship.

I understand that refusal to sign this contract will result in a discussion with my provider and may result in the termination of the patient-provider relationship.

PATIENT SIGNATURE *