adapt
Integrated Health Care

Substance Use Treatment

NEW PATIENT PACKET

www.adaptoregon.org

Dear New Patient:

Welcome to Adapt Integrated Health Care! We look forward to being a partner in your health.

At Adapt Integrated Health Care, there is no wrong door to care. Whether you're seeking medical care, mental health care, or substance use treatment, our providers and staff work together to meet your health care needs. We welcome new patients of all ages– children, teens, adults, and seniors.

As a patient of Adapt Integrated Health Care, you and your provider will work with other health professionals to coordinate your care. This is called your health care team. The most important person on your team is you. When you have concerns about your health, your health care team will help you get the services you need, when you need them.

Your health care team will keep a complete record of your medical history, health status, medications, test results, self-care information, and care received from other doctors. By getting to know you, your team can help you understand your healthcare needs and provide you with the information you need to manage your health.

To get started, just call or drop by our office to schedule your new patient appointment. In the following pages is information to help you prepare for new patient appointments for medical care, mental health care or substance use treatment. Our staff will help you complete new patient paperwork and discuss payment or insurance billing options. If you'd like to speed up your first visit? Fill out your new patient packet ahead of time. You may print forms at home or request a packet be sent to you in the mail. We will provide you with a self-addressed, stamped return envelope.

Thank you for choosing Adapt Integrated Health Care as your health care home.

Sincerely,

Your Adapt Integrated Health Care Team

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New Patient Information

Clinic Locations, Phone Numbers & Hours

	Phone	Hours	After Hours
Patient-Centered Primary Care			
Roseburg Clinic 621 W Madrone Street, Roseburg, OR 97470	(541) 440-3500	Mon–Thu, 7am–6pm Fri, 7am–5pm *Closed Sat & Sun*	*After-hours answering service (541) 440-3500*
Winston Clinic 671 SW Main Street, Winston, OR 97496	(541) 492-4550	Mon–Thu, 7am–6pm Fri, 7am–5pm *Closed Sat & Sun*	
Mental Health Care			
Roseburg Office 621 W Madrone Street, Roseburg, OR 97470	(541) 440-3532	Mon-Fri, 8am-5pm *Closed Sat & Sunday*	*After Hours & Weekends call the 24-Hour Crisis Line 1-(800) 866-9780*
Youth & Family Mental Health 548 SE Jackson Street, Roseburg, OR 97470	(541) 229-8434	Mon-Fri, 8am-5pm *Closed Sat & Sunday*	
Psychiatric Services 621 W Madrone, Roseburg, OR 97470	(541) 229-8973	Mon-Fri, 8am-5pm *Closed Sat & Sunday*	
Reedsport Office 680 Fir Street, Reedsport, OR 97467	(541) 440-3532	By Appointment	
Substance Use Treatment			
Roseburg Office 621 W Madrone Street, Roseburg, OR 97470	(541) 672-2691	Mon-Fri, 8am-5pm *Closed Sat & Sunday*	*After Hours & Weekends call the 24-Hour Crisis Line 1-(800) 866-9780*

Patient Portal

For non-urgent communication with your provider, we encourage you to sign up for the secure online Patient Portal. The Patient Portal is a quick and easy way to review your health information, schedule appointments, and communicate with your provider. As a new patient, you will receive instructions on how to sign up for the Patient Portal. If you have questions or need assistance, please talk with a member of our reception team.

Prescription Refills

When you need a prescription refilled, please call your pharmacy directly, even if there are no refills remaining. Your pharmacy contacts and coordinates all refill requests directly with your health care team. Please allow 72-hours for prescriptions to be refilled.

Billing Questions

If you have questions concerning your statement, please contact the billing office using the telephone number listed on your statement.

Sliding Fee & Discount Application

Adapt Integrated Health Care is a preferred provider for most health insurance plans, and we welcome patients covered by Oregon Health Plan and Medicare. If you are uninsured, we offer a sliding fee discount based on family/household size and net income. No one is turned away due to inability to pay. Please refer to our Application for Financial Discount in this packet for more information.

Tobacco-Nicotine Free Campus

For the health and safety of our patients and staff, Adapt Integrated Health Care is a tobacco-free and nicotine-free campus. This means that smoking and the use of tobacco/nicotine products are prohibited at all times and on all properties. If you would like to quit using tobacco, please talk with a member of your health care team.

Service Animal Policy

Only service animals trained to do work or perform tasks for a person with a disability are allowed inside the clinic. Please talk with a member of your health care team for more information (printed information is available https://www.ada.gov/service_animals_2010.htm).

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Preparing For Your First Substance Use Treatment Visit

We offer a full-continuum of care for individuals and families with substance use disorders—from medical detox and residential care to outpatient treatment and after care. Our highly trained and dedicated counselors take a holistic approach to care—treating the mind, body and spirit—to help each individual on their personal journey to life-long health and recovery.

Who We Serve

Substance use treatment services are available for adolescents and adults. Services are provided in Douglas, Coos, Curry and Josephine counties.

How to Prepare for Your New Patient Substance Use Treatment Appointment

- ****PLEASE NO CHILDREN AT THE ASSESSMENT APPOINTMENT****
- **Allow up to 2 ½ hours for your first appointment. Be prepared to do a urine drug screen and bring the following information to your appointment (if applicable)**
- Bring picture ID—a current state or federal issued ID—for example, a driver's license, ID card, or passport
- Bring your insurance card to all appointments
- Make a complete list of all medications that you currently take (including vitamins and supplements), or bring the containers with you to your appointment, or bring a printout of your current medications from your pharmacy
- Verification of your Income & Reduced Fee Application
- $7.00 for DUII Manual
- DUII Referral from ADES and DMV Driving Record
- Court Documents

Appointments: Schedule / Reschedule / Cancellations

Please call Adult Outpatient Services at (541) 492-0152 or (541) 672-1761 if you have any questions or need to reschedule**.** This will allow us to offer the time slot to another patient.

Unexcused Group Treatment Absence

Group attendance is expected and very important to your success in treatment. Multiple unexcused absences **MAY** result in suspension from group and delays in your treatment experience.

Our Services

Adult Outpatient
- Adult Outpatient & Intensive Outpatient Treatment
- Opioid Treatment Program
- Problem Gambling Treatment
- DUII Treatment Services
- Peer Support Services
- Aftercare and Support

Adult Residential Treatment
- Adult Residential Treatment
- Sub-Acute Medical Detox

Children & Family Treatment
- Youth Outpatient Treatment
- Youth Residential Treatment
- Moms in Recovery

Housing & Day Treatment
- Fresh Start Day Treatment
- Eveningside Transitional Housing
- Hillside Terrace Transitional Housing

PATIENT-CLIENT REGISTRATION FORM

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PATIENT DEMOGRAPHICS
Full Legal Name (Last) (First) (MI)
Date of Birth **Age** **Last Name at Birth**
Social Security # **Driver's License #**
Gender/ Gender Preference *(please check one)* ☐ Male ☐ Female ☐ Other ☐ Choose not to disclose ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female
Sexual Orientation *(please check one)* ☐ Straight ☐ Bisexual ☐ Lesbian or Gay ☐ Something else ☐ Choose not to disclose
Patient's Sex Assigned at Birth *(please check one)* ☐ Female ☐ Male ☐ Unknown
Pronoun Preference *(please check one)* ☐ He/His ☐ She/Her ☐ They/Their ☐ Ze/Zir ☐ Decline to Answer ☐ Unknown
Mailing Address (Address) (City) (State) (Zip)
Home Address *(If different)* (Address) (City) (State) (Zip)
Phone *(please check your primary phone)* ☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ Message: _____
Email Address *(for patient portal)*
Preferred Communication Method *(for appointment-related contact)* ☐ Phone ☐ Text ☐ Email
Occupation **Employer** **Phone**
Employment Status *(please check one)* ☐ Full-Time ☐ Part-Time ☐ Seasonal/Temporary ☐ Self-Employed ☐ Retired ☐ Unemployed
Name of Spouse/Significant Other* **Date of Birth** **If you wish to permit the above person(s) to discuss your medical care and/or billing matters, please include this person on the Authorization for the Disclosure of Information form.*
Responsible Party Name (*Complete if other than patient*) **Date of Birth**
Social Security # **Employer** **Phone**
INSURANCE INFORMATION Please provide copies of your insurance card(s)
Name of Primary Insurance
Group # **Policy #**
Policyholder (PH) Name **PH Date of Birth**
PH Social Security # **PH Relationship to Patient**
Name of Secondary Insurance *(If applicable)*
Group # **Policy #**
Policyholder (PH) Name **PH Date of Birth**
PH Social Security # **PH Relationship to Patient**

PATIENT-CLIENT REGISTRATION FORM

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PATIENT/CLIENT STATISTICS
As a Nonprofit Organization, we receive grant dollars and we are required to gather the following statistics about the patients/clients we serve on an annual basis. This information is **confidential** and will be used for statistics purposes **only**. We appreciate you taking the time to fully complete all questions in this section.
Check One for Each Question *(answer regarding the patient)*
Primary Language ☐ English ☐ Spanish ☐ ASL ☐ Other (specify)
Does client need an interpreter? ☐ Yes ☐ No If yes, circle which: ☐ Foreign Language ☐ Hearing
Would you be better served in a language other than English? ☐ Yes ☐ No
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Student Status ☐ Full-Time ☐ Part-Time ☐ Not a Student
Is the patient a veteran? ☐ Yes ☐ No **Immediate Family Member a Veteran** ☐ Yes ☐ No
Referral Source ☐ Outreach Coordinator ☐ Friend ☐ Relative ☐ News Media-Newspaper ☐ Radio ☐ Television ☐ Facebook ☐ Ad-Digital ☐ Direct Mail ☐ Billboard ☐ Other (specify)
Please indicate the stability of your current living status ☐ Permanent (Stable) ☐ Temporary (Unstable)
Current Living Situation ☐ Own Home ☐ Rent ☐ Temporary Housing ☐ Staying with friends/relatives (double up) ☐ Public Housing ☐ Transitional Housing ☐ Shelter ☐ Street ☐ Other
Agricultural Work Status ☐ Non-Agricultural ☐ Agricultural-Seasonal ☐ Agricultural-Migrant ☐ Agricultural-Employed Year-Round ☐ Retired Farmworker
Are you Hispanic or Latino? ☐ Yes ☐ No
Race *(Check all that apply)* ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race ☐ Refuse to Report
Client's Current Tribal Affiliation: ☐ **Not Applicable** ☐ Burns Paiute Tribe ☐ Cow Creek Band of Umpqua Tribe ☐ Confederated Tribes of Grant Ronde ☐ Confederated Tribes of Coos/Lower Umpqua/Siuslaw ☐ Confederated Tribes of Umatilla ☐ Coquille Indian Tribes ☐ Confederated Tribes of Warm Springs ☐ Other (please specify):
What is your gross (before taxes) household income? Per Month: **OR** Per Year:
How many people are in your household, including yourself?
Do you receive TANF Cash Benefits? ☐ Yes ☐ No
Highest School Grade Client Completed:

Patient or Guardian / Personal Representative signature (circle one)

Date

Printed name of Patient

Relationship, if not Patient

Due Date _____

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FINANCIAL DISCOUNT APPLICATION INFORMATION

Please retain this page for your reference.
Complete the next page and return it to Adapt by the due date if you wish to apply.

Adapt is a private, non-profit organization that provides quality and affordable medical services. All patients may apply for a sliding scale discount; eligibility is based on household size and income. *No one* is turned away due to lack of funds. All patients will receive a monthly statement if there is a balance owed on their account. All balances are due within 30 days of the statement date. If you are unable to pay your balance in full, please call Adapt's billing office to make payment arrangements.

Information you provide on this application will be used to help determine if you also qualify for a discount on services provided by Mercy Outpatient Lab & Imaging ordered by Adapt Primary Care. Information on this form may be requested by Mercy and will be provided to them for auditing purposes.

- Please complete this entire form and provide all requested documents to be considered for a sliding scale discount. Discounts will only be given to patients who qualify and provide verification.
- You have **14 days from the date of service** to complete and return this form to be considered for a discount on your visit. Otherwise, your discount will begin on the date it is returned.
- Adapt will not back date discounts.
- Once your application has been processed, you will receive a letter in the mail notifying you of the discount that you are eligible for.
- All discounts will be valid for one year at which time you will be asked to provide current verification. **If your financial or living circumstances change before this date, you are required to notify Adapt.** This information may adjust your discount.

Required Documents: To be determined for a sliding scale discount, please ensure copies of the following documents *for ALL household members are included with your application.* **If one or more of these documents do not pertain to your household, please disregard those documents.**

- ☐ Most recent 30 days of pay stubs
- ☐ Unemployment verification
- ☐ Most recent federal tax return (if self-employed)
- ☐ Social Security and/or Disability award letters
- ☐ Pension award letter
- ☐ Child Support award letter
- ☐ Worker's Compensation award letter
- ☐ Court orders from any lawsuit
- ☐ Proof of gambling winnings
- ☐ Proof of annuity payments
- ☐ Receipts for goods sold or services provided
- ☐ If you have no income, a letter that explains your means of living or a completed Self Attestation of Income form (available upon request)
- ☐ Food Stamps verification
- ☐ Tuition assistance grants

Definitions

Household: persons who live in the same dwelling and are pooling resources.

Income: any moneys received, whether taxable or non-taxable, from any source. Any moneys for goods sold or services provided, grants for tuition assistance, retirement income, business income, social security and/or disability payments, unemployment insurance benefits, settlement awards from any lawsuit whether considered "economic damages" or not, life insurance payments, annuity payments, gambling winnings, and any other moneys received for the purposes of assisting with household expenses will be included. Loans or available credit will not be counted.

If you are applying for a sliding scale discount, you may also qualify for the Oregon Health Plan (OHP). If you wish to apply for OHP and would like free assistance applying, please ask to speak with an outreach eligibility worker. To be considered for a discount from Mercy Medical Center, you must have applied for OHP.

Have you applied for the Oregon Health Plan? **Y N** If yes, date applied: Were you approved? **Y N**

Do you have other insurance? **Y N** If yes, what insurance? Adapt staff initials:

PLEASE PROVIDE INFORMATION FOR THE PERSON RESPONSIBLE FOR THIS ACCOUNT BELOW.

Name of Responsible Party: Relation to Patient:

SSN: DOB: Phone:

Billing Address: City: State: Zip:

Please provide information for all household members. (See definition of household on page 1)

Household Member	**1**	**2**	**3**	**4**	**5**	**6**
Name						
Date of Birth						
Relationship to Patient	SELF					
Gross Monthly Income from the following:	**Please provide supporting documentation for each source of income listed.**					
Salary/Wages	$	$	$	$	$	$
Unemployment	$	$	$	$	$	$
Social Security	$	$	$	$	$	$
Disability	$	$	$	$	$	$
Pension	$	$	$	$	$	$
Retirement	$	$	$	$	$	$
Child Support	$	$	$	$	$	$
Worker's Comp	$	$	$	$	$	$
Sale of Goods	$	$	$	$	$	$
Other ________	$	$	$	$	$	$
TOTAL	**$**	**$**	**$**	**$**	**$**	**$**

TOTAL gross monthly household income: _________ **TOTAL** number of household members: _______________

If your household income is zero, please initial here: _______ and provide a brief explanation of your current financial and living situations: ____

I hereby authorize representatives of Adapt to make whatever inquiries necessary to verify the information furnished on this form, or to release any information regarding my office visits to any insurance company or third party to seek settlement of this account. I hereby state that to the best of my knowledge the information given above is true and complete. I understand that if any information is found to be incorrect I may not be eligible for any future consideration of reduced rates and that any sliding fee taken in the past may be reversed and all accounts adjusted accordingly.

Patient/Responsible Party Signature: ____________________________________ **Date:** ________________________

FOR OFFICE USE ONLY

Application Date: ____ Expiration Date: ____

☐ **Based on the information provided, the above listed patient is eligible for a _____% discount.**

☐ **Based on the information provided, the patient is not eligible for a discount at this time.**

Information verified by: ☐ Pay Stubs ☐ Tax Return ☐Other ____

Staff member completing form: ____ Date: ____________________________

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SUBSTANCE USE TREATMENT
CLIENT HEALTH HISTORY FORM

Today's Date			
Last Name:	First Name:	Middle Initial	Birthdate:

SUBSTANCE USE TREATMENT INFORMATION & DETOX STATUS

Have you ever taken any of the following Anti-Anxiety Medications (Benzodiazepines)?

☐ Ativan ☐ Dalmane ☐ Halcion ☐ Prosom ☐ Serax
☐ Xanax ☐ Doral ☐ Niravan ☐ Restoril ☐ Tranxene

If yes, date of last use: Is it a current prescription? ☐ Yes ☐ No Prescribed to you? ☐ Yes ☐ No

Do you have any past/present withdrawal symptoms from alcohol or anti-anxiety medication? ☐ Yes ☐ No
If yes, please list the symptoms:

Current Drug Used	Use in Last 7 Days	Use IV?	How Often/How Much?	How Long?

Tobacco use: ☐ Never ☐ Previous Use ☐ Current Use If using: ☐ Smoke ☐ Smokeless ☐ Vape

How much / How often do you use tobacco? Do you have a Medical Marijuana card? ☐ Yes ☐ No

Have you been in treatment before? ☐ Yes ☐ No If yes, please list program(s) and year:

How many self-help support groups (AA, NA, etc.) do you attend in a typical months?

MEDICAL INFORMATION

Are you currently pregnant? ☐ Yes ☐ No ☐ Maybe If yes, how far along are you?

Primary Care Physician Name: Phone:

Dental Provider Name: Phone:

Do you need assistance finding a Primary Care Physician or Dental Provider? ☐ Yes ☐ No

Do you have a history of:

☐ Liver Disease	☐ Vision Problem	☐ Dental Problem
☐ Heart Attack, Stroke, Heart Surgery	☐ High Blood Pressure	☐ Headaches (frequent/severe)
☐ Seizure	☐ Hallucinations	☐ Chronic Cough
☐ DT's	☐ Diabetes	☐ Back Injury/Pain
☐ Head Injuries	☐ Other Chronic Medical Condition	☐ Eating Disorder
		☐ Chronic Pain

If any conditions are checked, please explain:

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Any Allergies to: ☐ Medications ☐ Bee Stings ☐ Foods List allergies:

Have you been diagnosed with: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV

If yes, do you need treatment for Hepatitis C / HIV? ☐ Yes ☐ No

If no, do you want to be tested for Hepatitis C / HIV? ☐ Yes ☐ No

Have you been tested for TB? ☐ Yes ☐ No If yes: ☐ Positive ☐ Negative Current TB Card? ☐ Yes ☐ No

Current Medications? ☐ Yes ☐ No **Do you have a 30-day supply?** ☐ Yes ☐ No Need Refill? ☐ Yes ☐ No

List Medications and Amounts (if available):

Medication Name	Amount	Medication Name	Amount

BEHAVIORAL HEALTH STATUS

Are you currently experiencing any of the following symptoms?

☐ Depression ☐ Mood Swings ☐ Panic/Anxiety ☐ Paranoia ☐ Hallucinations

☐ Suicidal Thoughts or Plan If you checked suicidal thoughts or plan, please describe:

Have you ever been diagnosed with a mental illness? ☐ Yes ☐ No Diagnosis:

Current Mental Health Provider Name: Phone:

Have you ever had to lie to people important to you about how much you have gambled? ☐ Yes ☐ No

Have you ever felt the need to bet more and money? ☐ Yes ☐ No

LEGAL STATUS

☐ Parole ☐ Probation ☐ Mental Health Court ☐Drug Court ☐ Incarcerated ☐ None ☐ Other:

Do you have any Pending Court Cases? ☐ Yes ☐ No If yes, for what?

Do you have any current or previous charges for Violent Offense? ☐ Yes ☐ No Sexual Offense: ☐ Yes ☐ No

How many times have you been arrested for DUII? Other charges?

Check agencies you're involved with: ☐ Mental Health ☐ Voc Rehab ☐ Bay Cities ☐ Translink ☐ CWP

Child Welfare Case Worker: **Parole/Probation Officer:**

Do you have any Family or Friends who work for Adapt Integrated Health Care? ☐ Yes ☐ No

If yes, please list name(s) and department:

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HAD SCALE

Patient's Name:	**Date of Birth:**
Counselors are aware that emotions play an important part in most addictions. If your counselor knows about these feelings, he or she will be able to help you more. This questionnaire will help your counselor know how you feel. Read each item and **circle** the best answer to show how you have been feeling **in the past week**.	

I feel tense or "wound up" **3 Most of the time** **2 A lot of the time** **1 Time to time, occasionally** **0 Not at all**	**I feel as if I am slowed down** 3 Nearly all of the time 2 Very often 1 Sometimes 0 Not at all
I still enjoy the things I used to enjoy 0 Definitely 1 Not quite as much 2 Only a little 3 Not at all	**I get sort of frightened feeling like "butterflies in the stomach"** **0 Not at all** **1 Occasionally** **2 Quite often** **3 Very often**
I get a sort of frightened feeling like something awful is going to happen **3 Very definitely and quite badly** **2 Yes, but not too badly** **1 A little, but it doesn't worry me** **0 Not at all**	**I have lost interest in my appearance** 3 Definitely 2 I don't take as much care as I should 1 I may not take as much 0 I take just as much care
I can laugh and see the funny side of things 0 As much as I always could 1 Not quite so much now 2 Definitely not so much now 3 Not at all	**I feel restless as if I must be on the move** **3 Very much indeed** **2 Quite a lot** **1 Not very much** **0 Not at all**
Worrying thoughts go through my mind **3 A great deal of time** **2 A lot of the time** **1 From time to time but not too often** **0 Only occasionally**	**I look forward with enjoyment to things** 0 As much as I ever did 1 Rather less than I used to 2 Definitely less than I used to 3 Hardly at all
I feel cheerful 3 Not at all 2 Not often 1 Sometimes 0 Most of the time	**I get sudden feelings of panic** **3 Very often indeed** **2 Quite often** **1 Not very often** **0 Not at all**
I can sit at ease and feel relaxed **0 Definitely** **1 Usually** **2 Not often** **3 Not at all**	**I can enjoy a good book or radio or TV program** 0 Often 1 Sometimes 2 Not often 3 Very seldom

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A Score (bold): _____ D Score: _____ <7 not present; 8-10 doubtful; ≥ 11 definite

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LIFE EVENTS CHECKLIST

Patient's Name:	**Date of Birth:**

Listed below are several difficult or stressful things that sometimes happen to people. For each event, **check one or more of the boxes** to the right to indicate that: (a) it ***happened to you*** personally, (b) you ***witnessed it*** happen to someone else, (c) it ***doesn't apply*** to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, or earthquake).			
2. Fire or explosion			
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash).			
4. Serious accident at work, home, or during recreational activity.			
5. Exposure to toxic substance (for example, dangerous chemicals, radiation).			
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)			
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)			
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)			
9. Other unwanted or uncomfortable sexual experience			
10. Combat or exposure to a warzone (in the military or as a civilian)			
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)			
12. Life-threatening illness or injury			
13. Severe human suffering			
14. Sudden, violent death (for example, homicide, suicide)			
15. Sudden, unexpected death of someone close to you			
16. Serious injury, harm, or death you caused to someone else			
17. Any other very stressful event or experience			

Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995

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INFECTIOUS DISEASE RISK ASSESSMENT FORM

This form is used for educational and referral purposes only.
It is not included in the treatment file and shredded after initial assessment.

1. In the past 12 months have you had a tattoo, body piercing, acupuncture or have had contact with someone else's blood?	☐ Yes ☐ No
2. Within the last 30 days, have you had any of the following symptoms <u>lasting for more than 2 weeks</u>?	
☐ Nausea ☐ Shortness of Breath ☐ Night Sweats (so bad that you had to change your clothes/sheets) ☐ Fever ☐ Weight Loss (unintentional) ☐ Productive Cough ☐ Diarrhea (lasting more than 1 week) ☐ Women—Have you missed your last two periods ☐ Coughing Blood ☐ Lumps/swollen gland in neck or armpit	
3. Have you ever been told you have TB?	☐ Yes ☐ No
4. Has anybody you know or have lived with been diagnosed with TB in the past year?	☐ Yes ☐ No
5. Have you ever had a positive skin test for TB? (A test where they gave you a shot in your forearm, and a few days later a hard bump appeared.)	☐ Yes ☐ No
6. Have you ever been treated for TB?	☐ Yes ☐ No
7. Have you ever been told that you have: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C	
8. Do you use needles to shoot drugs or shared needles or syringes to inject drugs?	☐ Yes ☐ No
9. Have you ever had a job that put you in danger of needle stick injuries or other types of blood contact?	☐ Yes ☐ No
10. Do you use stimulants (cocaine/methamphetamine)?	☐ Yes ☐ No
11. In the last 12 months, have you or anyone you have had sex with had (STDS), like syphilis, gonorrhea, herpes, chlamydia, nongonococcal urethritis, other sexually transmitted diseases, or hepatitis?	☐ Yes ☐ No
12. Did you have a blood transfusion before 1992 or received blood products produces before 1987 for clotting problems?	☐ Yes ☐ No
13. Was your birth mother infected with Hepatitis C virus during the time of your birth?	☐ Yes ☐ No
14. Have you been, or are you currently, on long term dialysis?	☐ Yes ☐ No
15. Have you had sex with someone who has the blood disease hemophilia?	☐ Yes ☐ No
16. Have you had unprotected sex with a person who injects drugs or with a man who has sex with other men?	☐ Yes ☐ No
17. Have you had sex in exchange for money or drugs, or to survive?	☐ Yes ☐ No
18. Have you had sex with more than one person in the past 6 months? Any types of vaginal, rectal or contact without protection (condom or other barrier) with or without your consent?	☐ Yes ☐ No
19. Have you had sex <u>or</u> shared needles to inject drugs with a person who has AIDS <u>or</u> who tested positive on the antibody test for AIDS/HIV disease or Hepatitis C?	☐ Yes ☐ No
20. Have you ever injected drugs, even once?	☐ Yes ☐ No
21. Have you ever been pricked by a needle or syringe that may have been infected with HIV or Hepatitis C Virus?	☐ Yes ☐ No
22. Have you ever had a drinking problem that required medical care or counseling, or have you ever been told or thought that you have a drinking problem?	☐ Yes ☐ No

The following questions are asked to help with treatment planning.
It is not required that you answer them to participate in assessment and/or treatment.

1. Have you ever had a blood test for the HIV antibody?	☐ Yes ☐ No
If No, would you like a blood test?	☐ Yes ☐ No
If Yes, have you been tested within the last 6 months?	☐ Yes ☐ No
2. Have you ever had a blood test for the Hepatitis C Virus?	☐ Yes ☐ No
If No, would you like a blood test?	☐ Yes ☐ No
If Yes, have you been tested within the last 6 months?	☐ Yes ☐ No

3. How would you judge your own risk for being infected with HIV (the AIDS virus)?

☐ I know I am infected.
☐ I think I am at high risk.
☐ I think I am at low risk.
☐ I think I am at NO risk.
☐ I am not sure what my risk is.

4. How would you judge your own risk for being infected with the Hepatitis C Virus?

☐ I know I am infected.
☐ I think I am at high risk.
☐ I think I am at low risk.
☐ I think I am at NO risk.
☐ I am not sure what my risk is.

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PATIENT ACKNOWLEDGEMENT AND CONSENT OF AGENCY POLICIES

Consent for Medical Treatment

I consent to receiving medical and/ or surgical treatment including, but not limited to: diagnostic tests, lab work, injections, minor operations, and removal/ disposal of tissues as may be deemed advisable or necessary by the attending healthcare provider.

Consent for Behavioral Health Services

I consent to receiving behavioral health services as may be appropriate to assist with my medical treatment including, but not limited to assessment of and treatment for mental health conditions and/ or substance misuse.

Patient Rights

In addition to the HIPAA Notice of Privacy Practices, I understand that it is Adapt's policy to offer patients a printed copy and chance to review the following upon admission to any of Adapt's state certified behavioral health programs:

- Individual Rights Policy
- Grievance Policy and Form
- Service Delivery Policies

Advanced Directives

I acknowledge that Adapt provides an opportunity at admission to complete or provide copies of any advanced directives. If I receive services from any of Adapt's state certified behavioral health programs, staff will provide me information about the Oregon Declaration for Mental Health Treatment Form, its purpose, and contact information for a person who can answer additional questions.

Release of Information

I acknowledge that Adapt's Notice of Privacy Practices was provided to me and any use or release of information not permitted under law will require my authorization to release information. I authorize Adapt to release to my insurance carrier(s) by mail, fax, electronically, or verbally, any information needed to determine benefits payable and to bill for services provided. Some Adapt departments fall under additional federal privacy protections for substance use treatment programs. If my services include any 42 CFR Part 2 protected information, Adapt will ask for my written authorization on a release of information form before billing my insurance.

Informed of Ancillary Service Providers and Staff

I understand that from time to time, other persons may be observing or facilitating my care including, but not limited to students of the health profession, and administrative or health care professionals in orientation or training.

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Disability Certification and Special Accommodations

I understand that the health center limits services provided to those that are clinical in nature. Any requests for additional administrative services, like disability certification and special accommodations, that require a determination of disability will have to be provided by a medical or behavioral health provider at another location. Paperwork for short-term disability or FMLA/OFLA by an Adapt provider may be completed and will be subject to a $25 administrative fee. The reason for this policy is to avoid having the performance of administrative functions interfere with patient care.

Financial Responsibility & Billing Consent

All clients are responsible to pay in full for all services. I understand that it is my responsibility to check with my insurance company to verify coverage of services. I understand that I am responsible for any deductibles, co-pays, coinsurance, non-covered services or services deemed “not medically necessary" by my insurance company. Co-pays and coinsurance will be collected at the time of service. I may also choose to not bill my insurance for a specific visit, and I will then be responsible for the full cost of undiscounted services provided to me at that visit. I understand if my check is returned for non-sufficient funds (NSF) or written on a closed account, I will be responsible for a $25 processing fee. I understand that if I do not make my scheduled payments and/ or do not make payment arrangements Adapt’s billing department, my account may be assigned to a third-party collection agency.

Assignment of Insurance Benefits

I understand that this serves as a direct assignment of my medical benefits from Medicare, Medicaid, other government carrier, or any commercial/ private insurance carrier, to be paid to Adapt. If I receive payments directly from my insurance company, I agree to bring them to Adapt for payment on my account.

Laboratory Information:

- In-clinic tests are courtesy billed to insurance companies by Adapt
- Samples collected and sent to outside labs will be billed by the performing laboratory. Some locations have Mercy and Cordant available on-site for patient convenience but are not part of Adapt.

Referrals

I understand that I may choose to receive diagnostic test(s} or health care treatment/service at a facility other than the one recommended by my health care practitioner. I understand that if I choose to have the diagnostic test, health care treatment or service at a facility different from the one recommended by my health care practitioner, I will be held responsible for determining the extent of coverage or the limitation on coverage as applicable. A health practitioner may not deny, limit or withdraw a referral solely because I choose to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health care practitioner.

Voter Registration

I understand that staff will offer an opportunity to register to vote during admission.

By reading and signing this form, I accept my rights and responsibilities as a patient and consent to the treatment and services provided by Adapt. In addition, by signing this form, I certify that I have not withheld insurance coverage information existing at the time of this service and that no other insurance coverage exists beyond that which I have provided. I accept full responsibility for all charges whether they are covered by insurance or not. I have authorized Adapt to release all information necessary to my insurance company to make payment. I have read and understand the above information and give authorization for payment of insurance benefits to be made directly to Adapt for services provided.

Patient or Guardian / Personal Representative signature (circle one)

Date

Printed name of Patient

Printed name of Signatory and relationship, if not Patient

Mailing: PO Box 1121, Roseburg, OR 97470
Website: https://www.adaptoregon.org/

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Integrated Health Care

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. • Requests are submitted in writing. Ask staff for a form
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days. • Requests are submitted in writing. Ask staff for a form
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests. • Requests are submitted in writing. Ask staff for a form.

Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.
	• Requests are submitted in writing. Ask staff for a form

Your Rights *continued*

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. • Requests are submitted in writing. Ask staff for a form
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting the Privacy Officer 541-492-0129 • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting the Privacy Officer 541-492-0129 • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care or someone who helps pay for your care. • Share information in a disaster relief situation • Contact you for fundraising efforts *For example, we may assume you agree to our sharing of your information to your spouse when you bring your spouse with you into the exam room or while treatment is discussed. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.* *We may also share your information when needed to lessen a serious and imminent*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes • Other uses and disclosures not described in this notice.
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A provider treating you for an injury asks another provider about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

Our Uses *continued*

Business associates	• We may contract with business associates (BA) to perform certain functions or activities on our behalf. These BA's must agree to protect your health information	***Example:*** *Legal, billing, transcription, consulting, EMR hosting activities*
Appointment reminders	• Your information allows us to contact you about appointments for treatment or other health care you may need	***Example:*** *To contact you as a reminder that you have an appointment or communicate a change*
Give treatment alternatives & services	• In some instances, the law permits us to contact you.	***Example:*** *To describe our services; for your treatment; for case management and care coordination; to recommend available treatment options*
Health Information Exchanges	• We participate in multiple internet-based health information exchanges. The sharing of your health information is to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions.	***Example:*** *OCHIN Care Collaborative, EPIC Care Everywhere, Reliance*
Specific Types of PHI	• There are stricter requirements for use and sharing of some types of health information. However, there are still situations in which these types of information may be used or shared without your authorization. • If you are a client in one of our 42 C.F.R. Part 2 substance use treatment programs, please see "*Notice to Patients of Federal Confidentiality Requirements under 42 C.F.R. Part 2*" for more information. • If you are a client in a Part 2 substance use treatment program, we will not disclose your information without your authorization unless otherwise permitted under the law.	***Example:*** *Substance Use Disorder information, mental health, and HIV or genetic testing information*
Coordinated Care Organizations (CCO)	• If you are insured by a CCO with the Oregon Health Plan, there are time when we must share your health information for general purposes like service delivery, care coordination, transitional services, and payment. • If the information includes Part 2 records, we will obtain your authorization.	***Example:*** *Umpqua Health Alliance (UHA), All Care, Advanced Health*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Law enforcement	• We may share health information to authorized officials for law enforcement purposes (ex: to respond to a search warrant, report a crime on our premises or against our staff, or help identify or locate someone).
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.htm**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: 3/31/2021

This Notice of Privacy Practices applies to the following Adapt Integrated Health Care Programs and Sites:

- South River Community Health Center at Winston main campus, Winston Cascade Center, and Roseburg Madrone campus
- Compass Behavioral Health
- Adapt's Part 2 Substance Use Disorder Treatment Programs: Adult Residential Program at the Crossroads, Youth Residential Program at Deer Creek, Detoxification Program, Opioid Treatment Program, Outpatient Adult and Youth Substance Use Treatment Programs

Adapt Integrated Health Care and sites listed above may share your protected health information with each other. They would do this to provide you with quality health care, to pay for your care, and to conduct our operations. Adapt is committed to providing high quality care across the full range of integrated health, recovery, support, and prevention services. For this reason, we may use and share your information among these programs in order to make decisions about, and plan for, your care and treatment. We also may use it to refer to, consult with, coordinate among, and manage alongside other healthcare providers for your care and treatment.

Adapt Integrated Health Care ("Adapt") is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org as a Business associate of Adapt. OCHIN supplies information technology and related services to Adapt and other OCHIN participants. OCHIN also engages in quality Adapt assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by Adapt with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive. The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

Adapt Integrated Health Care
PO Box 1121
Roseburg, Oregon 97470
www.adaptoregon.org
Privacy Officer contact number: 541-492-0129

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AUTHORIZATION FOR USE AND DISCLOSURE
ACKNOWLEDGEMENT OF TEXTING RISK

For services provided by Adapt Integrated Health Care, hereafter referred to as the "Health Center"

By completing this form, I authorize all Health Center office staff, healthcare providers, and any agents or independent contractors acting at and under the direction of same to leave messages regarding appointments, test results, or diagnostic results on my answering machine/voicemail at the designated number(s), and/or with the designated family member/friend(s), and/or to disclose my health information to the designated family member/friend(s) as described below.

Health Center's policy is to discourage staff from communicating with clients via text. Communicating through text messages can lead to unintended consequences. Private information, your role as a client/patient at Health Center, or Protected Health Information (PHI) may be seen by people who you do not want to see it.

If you choose to have staff communicate with you by text because you have no other way to communicate or you prefer it, here is a list of possible ways your information could be inadvertently disclosed. There may be other ways in which this texting can result in your information being disclosed that are not on this list. Some things to consider:

- Messages are often displayed on the phone automatically and you may not be nearby to monitor the device—a person could inadvertently or intentionally read a message
- A person could use the phone pretending to be you and the person on the other end would not know
- If a person gets access to your phone when you are not present, they could read through sent and received texts, even months or years later

If I request that a Health Center staff member communicate with me via text and I choose not to use a secure app, I understand that I may be putting my confidentiality and privacy at risk. By signing this form, I am acknowledging that I have been advised of the risk and I will hold Health Center harmless for any disclosures that occur because of this method of communication.

I am also consenting to receive text reminders for upcoming appointments. I understand that I can opt out at any time by text STOP to the appointment reminder text message.

Please initial or mark as not applicable (N/A) all authorization(s):

_____ Authorization to leave messages concerning appointment information, test results or diagnostic results on the following answering machine/voicemail(s) or email.

_____	_____	_____	_____
(Home phone)	(*Cell phone)	(Message phone)	(Email)

Please choose: _____ VOICE _____ TEXT

If you are not available at the time that we call, please list below those individuals with whom we can leave a message or briefly discuss your medical information.			Authorization to leave messages concerning appointment information with designated family member/friend(s).	Authorization to disclose my health information to designated family member/friend(s).
Name	**Relationship**	**Phone Number**	***Initial Below***	***Initial Below***

I have read and agree to the statements above.

Patient or Guardian / Personal Representative signature (circle one)

Date

Printed name of Patient

Printed name of Signatory and relationship, if not Patient

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INFORMED CONSENT FOR TELEHEALTH SERVICES

For services provided by Adapt Integrated Health Care,
hereafter referred to as the "Health Center"

1. I understand that telehealth is the use of electronic information and communication technology to deliver health care services including, but not limited to, the assessment, diagnosis, consultation, treatment, education, care management and or self-management of a patient, when the patient is located at a different site than the provider.
2. I understand that my health care provider wishes me to engage in a telehealth intervention.
3. My health care provider has explained to me how the electronic information and communication technology will be used during the visit and will not be the same as a direct patient slash health care provider visit due to the fact that I will not be in the same room as my health care provider.
4. I understand there are potential risks of this technology, including interruptions, unauthorized access and technical difficulties that may lead to an inability to obtain information sufficient for decision making about my health problem and that all reasonable precautions will be taken to minimize these risks. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the video conferencing connections are not adequate for the situation.
5. I have had the alternatives to telehealth consultation explained to me. In choosing to participate in a telehealth consultation, I understand that some parts of the exam involving physical tests may not be conducted or may be conducted by individuals at my location at the direction of the consulting health care provider.
6. I understand that my health care information may be shared with other individuals for treatment, payment, or operations purposes, in accordance with Oregon and federal privacy rules and the Notice of Privacy Practices. Others may also be present during the consultation in addition to my health care provider in order to operate the communication equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and will have the right to request the following
    a. Omit specific details of my medical history/physical examination that are personally sensitive to me
    b. Ask non-medical personnel to leave telehealth examination room and or
    c. Terminate the consultation at any time.
7. My questions have been answered in the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

8. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care treatment. I may revoke my consent orally or in writing at any time by contacting Health Center at (541) 672-2691.
9. I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit.
10. I understand that my telehealth visit will be documented in my medical record.
11. I understand that I have the right to select another provider and be notified that by selecting another provider, there could be a delay in service and the potential need to travel for a face to face visit.

I hereby give my informed consent for telehealth treatment.

Patient or Guardian / Personal Representative signature (circle one)

Date

Printed name of Patient

Printed name of Signatory and relationship, if not Patient

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SUBSTANCE USE TREATMENT
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I understand that Adapt Integrated Health Care (hereafter, Adapt) programs will use and disclose health information about me. Adapt programs include Crossroads Residential, Adult and Youth Outpatient, SouthRiver Community Health Center, Deer Creek Residential, and Adapt Corrections.

Adapt staff members may release information about me to other Adapt staff members that concerns substance abuse, HIV, genetic testing, sickle cell information, and mental health information. This information will be disclosed on a need-to-know basis as it relates to your care. This includes clinical and administrative processes.

Name of Patient: _____ **Date of Birth**: _____

FROM / TO	**TO / FROM**
Name **ADAPT PROGRAMS**	**Name**
Address **621 W. MADRONE ST.** **PO BOX 1121**	**Address**
City/State/Zip **ROSEBURG, OR 97470**	**City/State/Zip**
Phone/Fax **P 541-672-1761 / F 541-672-1688**	**Phone/Fax**

PURPOSE OF DISCLOSURE

Purpose of Disclosure: _____

Describe <u>each</u> purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.

I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

*****PLEASE INITIAL*****

_____ Alcohol/Drug Evaluation	_____Summary of Progress	_____ Treatment Discharge Summary
_____ Appointment Information	_____Emergency Contact	_____ UA Results/Reports
_____ Attendance Reports	_____Laboratory reports	_____ Other as specified

Dates of Service from:_____ to _____ (Only the most recent records will be released if not specified.)

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***Special Protected Information:** If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.**

_____ *Drug/Alcohol diagnosis, treatment and/or referral

_____ *Mental Health information including diagnosis and medication

_____ *HIV/AIDS information

_____ *Genetic testing information

_____ *Sickle cell information

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This Authorization will expire on _____ (date) or 1 year from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above described purpose.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have reviewed and I understand this Authorization. By signing this Authorization, I am directing you to disclose my health information to another person or organization that may not have or obey the same obligations to protect privacy that you do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized re-disclosure and loss of protection under state and federal law.

I have been provided a copy of this form.

Signature of Patient:	**Date:**
Signature of Person Signing Form if Not Patient:	**Describe Authority to Sign on Behalf of Patient:**

_____

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.