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Integrated Health Care

Psychiatric Medical Services

NEW PATIENT PACKET

www.adaptoregon.org

Packet Updated 3/13/23

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 Psychiatric Medical Visit

At Adapt Integrated Health Care, medical providers, behavioral medicine specialists, and community service workers will provide you with the services you need, when you need them—including specialty care for patients with diabetes, chronic pain, alcohol and substance use problems and other complex health conditions. At your first appointment, you will be able to talk with your health care team about your treatment needs and options.

How to Prepare For Your New Patient Medical Appointment

- Arrive 30 minutes before your new patient appointment
- 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
- Be prepared to pay your co-payment if required by your insurance plan
- 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
- Be prepared to discuss your top health concerns with your provider; follow-up appointments may be scheduled following your initial visit

Appointments: Schedule / Reschedule / Cancellations

Please call your provider's office as soon as you can. We request 24-hour notice for cancelled visits. This will allow us to offer the time slot to another patient.

Open Access Appointments

Our primary care and mental health clinics offer *Open Access Scheduling*—also known as same day appointments. To learn more about same day appointments, call your Primary Care clinic or Mental Health office.

Our Primary Care Services

Medical Care
- Preventive Care
- Acute Care
- Family Planning
- Men's & Women's Health
- STD Tests & Treatment
- Chronic Disease Care
- Diabetes Care
- Immunizations
- Lab and X-ray (CHI Mercy)
- Referrals to Specialty Care

Children's Health
- Well-Baby & Well-Child Exams
- Teen & Young Adult Health
- Sports Physicals

Behavioral Medicine Services
- Mental Health Counseling
- Substance Use Counseling
- Individual and Group Psychotherapy
- Medication-Assisted treatment
- Pain Management
- Chronic Illness Management
- Tobacco Cessation

Psychiatric Medical Services
- Medication Management
- Individual Psychotherapy
- Pediatric Medication Management

NEW PATIENT-CLIENT REGISTRATION FORM

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PATIENT INFORMATION

Full Legal Name:
(Last) (First) (MI)

Preferred Name:
(Last) (First) (MI)

Date of Birth: **Age:** **Last Name at Birth:**

Social Security #: **Driver's License #:**

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 Phone: _____ ☐ Email: _____

Patient's Occupation: **Employer:**

Employer's Phone:

Employment Status *(check one):* ☐ Full-Time ☐ Part-Time ☐ Seasonal/Temporary ☐ Self-Employed
☐ Retired ☐ Unemployed ☐ Active Military ☐ Disabled

Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a Student

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:**

NEW PATIENT-CLIENT REGISTRATION FORM

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PATIENT/CLIENT INFORMATION
As a non-profit organization, we receive grant funds and are required to gather the following information each year. The information you provide is confidential. **Please Check One for Each Question (answer regarding the patient).**
Primary Language: ☐ English ☐ Spanish ☐ ASL ☐ Other *(specify):*
Does patient need an interpreter? ☐ Yes ☐ No If yes, which: ☐ Foreign Language ☐ Hearing
Would you be better served in a language other than English? ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Domestic Partner
Is the patient a Veteran? ☐ Yes ☐ No **Dependent Child of Veteran?** ☐ Yes ☐ No **Spouse/Domestic Partner of Veteran?** ☐ Yes ☐ No ☐ Unknown
Referral Source: ☐ Outreach Coordinator ☐ Friend ☐ Relative ☐ News Media-Newspaper ☐ Radio ☐ Television ☐ Facebook ☐ Ad-Digital ☐ Direct Mail ☐ Billboard
Patient Housing Status: ☐ Vehicle ☐ Unstable ☐ Temporary ☐ Stable/Permanent ☐ Recovery Center ☐ Other
Homeless Status: ☐ At risk for homeless ☐ Child at risk for homeless ☐ Currently not homeless (was in last 12 mo) ☐ Homeless unknown shelter ☐ Living in shelter ☐ Living with others ☐ Not homeless ☐ Permanent supportive housing ☐ Single occupancy hotel ☐ Street, camp, bridge ☐ Transitional housing ☐ Veteran at risk for homeless
Public Housing (Section 8/HUD): ☐ Yes ☐ No
Migrant / Seasonal: ☐ Migrant ☐ Seasonal ☐ Neither
Are you Hispanic or Latino? ☐ Yes ☐ No
Race *(check all that apply):* ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Alaska Native ☐ American Indian ☐ Refuse to Report
Patient's Current Tribal Affiliation: ☐ **Not Applicable** ☐ Burns Paiute Tribe ☐ Cow Creek Band of Umpqua Tribe ☐ Confederated Tribes of Grant Ronde ☐ Coquille Indian Tribes ☐ Confederated Tribes of Coos/Lower Umpqua/Siuslaw ☐ Confederated Tribes of Umatilla ☐ Confederated Tribes of Warm Springs ☐ Other *(specify)*
Do you receive TANF Cash Benefits? ☐ Yes ☐ No
Source of Income *(check one):* ☐ Wages/Salary ☐ Public Assistance ☐ Retirement/Pension/SSI ☐ Disability/SSDI ☐ Other *(specify):*
Highest School Grade Patient Completed:

NEW PATIENT-CLIENT REGISTRATION FORM

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ADDITIONAL PATIENT INFORMATION (please answer all questions)
Adapt is a non-profit organization committed to serving the needs of our community. This information will help us access additional grants to continue helping uninsured and underserved residents and to identify patients who may qualify for special programs or services. The information will become part of your confidential patient record.
What is your gross (before taxes) household income? $ *(check one)* ☐ Month ☐ Year
How many people are in your household, including yourself?
Patient's Sexual Orientation *(check one):* ☐ Straight/Heterosexual ☐ Bisexual ☐ Something else ☐ Don't Know ☐ Choose not to disclose ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Queer ☐ Omnisexual ☐ Asexual
Patient's Gender Identity *(check one):* ☐ Female ☐ Male ☐ Transgender (F) ☐ Transgender (M) ☐ Other ☐ Choose not to disclose ☐ Nonbinary/Gender Queer ☐ Questioning ☐ Two Spirit
Patient's Sex Assigned at Birth *(check one)*: ☐ Female ☐ Male ☐ Intersex ☐ Not recorded on birth certificate
Pronoun Preference *(check one):* ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ ze/hir/hirs ☐ ey/em/eirs ☐ xe/xm/xyrs ☐ ve/vir/vis ☐ Other ☐ patient's name ☐ decline to answer ☐ unknown

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.

- 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.
- If applicable, information provided on this application may be used to determine if you qualify for a discount on services provided by Mercy Outpatient Lab & Imaging ordered by Adapt Primary Care. To be considered for a discount from CHI Mercy Health, you must have applied for Oregon Health Plan. Information on this form may be requested by CHI Mercy Health and will be provided to them for auditing purposes.

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.

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 <u>not</u> eligible for a discount at this time.**

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

Staff member completing form: _____ Date: _____

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PRIMARY CARE
ADULT PATIENT HEALTH HISTORY

Patient's Name:	**Birthdate:**	**Age:**	**Male / Female**
Current Medical Provider:	Reason for transferring care:		
Preferred Pharmacy:			

CURRENT HEALTH			
Present Health Concerns:			
MEDICATIONS: Please list ALL medications including vitamins, herbs, home remedies			
Medication Name	Strength (mg)	Directions	Reason Taking
Aspirin ☐ Yes ☐ No			
Verified by (Adapt staff initial):			

ALLERGIES: or reactions to medications, environmental, animals, food, vaccines, etc.	
Allergy	Symptoms or Reaction
Verified by (Adapt staff initial):	

HEALTH SCREENING QUESTIONNAIRE
Do you now or have you ever used tobacco? ☐ Current ☐ Previous ☐ Never
How many times in the past year have you had 4 or more drinks in a day? ☐ None ☐ 1 or more

One Drink =  **12 oz. beer**  **5 oz. wine**  **1.5 oz. liquor (1 shot)**

Do you sometimes use drugs recreationally, including marijuana or prescription drugs? ☐ No ☐ Yes
In the last 2 weeks have you been bothered by:
a) Little interest or pleasure in doing things? ☐ No ☐ Yes
b) Feeling down, depressed or hopeless? ☐ No ☐ Yes

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

MEDICAL HISTORY (Please indicate with an **X** all that apply)

- ☐ Brain Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Ovarian Cancer
- ☐ Pancreatic Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Tumor (benign)
- ☐ Tumor (malignant)
- ☐ Other Cancer:_____
- ☐ CHF
- ☐ DVT
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ MI (Heart Attack)
- ☐ Stroke
- ☐ Atrial Fibrillation
- ☐ Eye Disease
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Otitis Media (ear infections)
- ☐ Cataracts
- ☐ Dysplastic Moles
- ☐ Arthritis
- ☐ Chronic Back Pain
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Autoimmune Disorder
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Endocrine Issues
- ☐ Hyperthyroidism (high)
- ☐ Hypothyroidism (low)
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ TB (Tuberculosis)
- ☐ Chronic Headaches
- ☐ Epilepsy
- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Seizure Disorder
- ☐ Anxiety Disorder
- ☐ Bipolar
- ☐ Dementia
- ☐ Depression
- ☐ Development Disorder
- ☐ Psychiatric Illness
- ☐ Substance Abuse
- ☐ Suicide Attempt
- ☐ Other:
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ GERD
- ☐ GI Bleed
- ☐ Hepatitis_____
- ☐ Liver Disease
- ☐ Ulcer
- ☐ Ulcerative Colitis
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Urinary Disorder
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Transfusions
- ☐ Clotting Disorders
- ☐ Peripheral Vascular
- ☐ MRSA

SURGICAL HISTORY (Please indicate with an **X** all that apply)

- ☐ Hernia Repair
- ☐ Gallbladder Removed
- ☐ Gastric Surgery
- ☐ Small Bowel Resection
- ☐ Colon Resection
- ☐ Appendix Removed
- ☐ Breast Lumpectomy
- ☐ Mastectomy
- ☐ Breast Augmentation
- ☐ Coronary Artery Bypass
- ☐ Coronary Artery Stenting
- ☐ Heart Valve Surgery
- ☐ Craniotomy
- ☐ Other
- ☐ Peripheral Vascular Bypass
- ☐ Peripheral Vascular Stenting
- ☐ Aneurysm Repair
- ☐ Carotid Surgery
- ☐ Vein Surgery
- ☐ Lung Surgery
- ☐ Esophageal Surgery
- ☐ Bunion Surgery
- ☐ Hammer Toe Correction
- ☐ Repair Up Extremity Fracture
- ☐ Repair Low Extremity Fracture
- ☐ Arthroscopy
- ☐ Rotator Cuff Repair R / L
- ☐ ACL Repair
- ☐ Total Hip Replacement R / L
- ☐ Total Knee Replacement R / L
- ☐ Total Shoulder Replacement
- ☐ Carpal Tunnel Surgery R / L
- ☐ Prostate Surgery- Cancer
- ☐ Prostate Surgery for BPH
- ☐ Incontinence Surgery
- ☐ Kidney Removed
- ☐ Bladder Surgery
- ☐ Tonsillectomy
- ☐ Ear Tube Placement
- ☐ Hysterectomy
- ☐ Ovary Removed R / L
- ☐ C-Section
- ☐ Laparoscopy
- ☐ Bladder Suspension
- ☐ Cervical Surgery
- ☐ Lumbar Surgery
- ☐ Thoracic Spine Surgery
- ☐ Cataract Surgery
- ☐ Eyelid Surgery
- ☐ Sex Reassignment M to F
- ☐ Sex Reassignment F to M

SOCIAL HISTORY

Occupation:	Where Employed:	Education Level:
Lives With:	Marital Status:	Spouse's Name:
# of Children:	Nickname:	Religion:

Primary Language: ☐ English ☐ Spanish ☐ Other (specify):

Gender/ Gender Preference *(please check one)* ☐ Male ☐ Female ☐ Other ☐ Choose to disclose
☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female

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Patient Name: **Date of Birth:**

FAMILY HEALTH HISTORY

Please indicate with an X family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Mom's Sister	Mom's Brother	Dad's Mom	Dad's Dad	Dad's Sister	Dad's Brother
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Angina	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cervical Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Coronary Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Growth / Development Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung / Respiratory Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Melanoma / Skin Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Severe Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Weight Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Medical Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
No / Unknown Family History	☐											

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Patient Name:	**Date of Birth:**

TOBACCO USE

Current Tobacco Use: ☐ Never ☐ Former ☐ Current How much per day:

Type of Tobacco Use: ☐ Cigarette ☐ Cigar ☐ Smokeless (chew) ☐ Vape ☐ Pipe

Have you tried to quit? ☐ No ☐ Yes Method attempted: Passive smoke exposure? ☐ No ☐ Yes

ALCOHOL USE

Current Alcohol Use: ☐ Never ☐ Former ☐ Current Average # drinks per day: Type of alcohol:

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the Past

SUBSTANCE USE

Do You Use: ☐ None ☐ Methamphetamine ☐ Cannabis/Marijuana ☐ Inhalants ☐ Tranquilizers/benzodiazepines
☐ Cocaine ☐ Narcotics (opiates/narcotics/heroin) ☐ Hallucinogens ☐ Other
How often used? ☐ Daily ☐ Weekly ☐ Monthly

Reason for Use:

OTHER

Current Caffeine Use: ☐ Yes ☐ No Type: ☐ Coffee ☐ Soda ☐ Energy Drinks ☐ Other:

Exercise Routinely? ☐ Yes ☐ No How many times per week? Type of Exercise:

Vehicle Seatbelt Use: ☐ 100% of time ☐ 50% of time ☐ 25% of time ☐ Never

Sunshine Exposure: ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Do you use sunscreen? ☐ Yes ☐ No

Do you believe that you are at high risk for HIV? ☐ Yes ☐ No If yes, explain:

PREVENTATIVE CARE SCREENINGS

Please place an X next to each test and provide approximate date, results and place where it was done.

☐ Pap Smear Date: Results: ☐ Normal ☐ Abnormal Place:

☐ Colon Screening Date: Type: ☐ Colonoscopy ☐ Sigmoidoscopy ☐ Stool Hemoccult
Results: ☐ Normal ☐ Abnormal ☐ # of polyps removed Place:

☐ Breast Screening Date: Results: ☐ Normal ☐ Abnormal Place:

☐ Dexa Scan (bone density) Date: Results: ☐ Normal ☐ Abnormal Place:

☐ PSA (prostate level) Date: Results: ☐ Normal ☐ Abnormal Place:

Please bring immunization/vaccine history information to your first appointment.

WOMEN'S HEALTH

Are you now or are you planning to become pregnant in the next year?
☐ Currently Pregnant ☐ Not planning to become pregnant in next year ☐ Planning to become pregnant

Please place and X next to each option that applies.

☐ Hysterectomy	☐ Depa-DMPA Date of last shot:
☐ Bilateral Tubal Ligation Date:	☐ Condoms
☐ Hysteroscopic tubal Occlusion Date:	☐ Rhythm Method
☐ Implant/Nexplanon Date:	☐ Abstinence
☐ IUD Type: ☐ Mirena ☐ Paragard ☐ Skyla Date:	☐ Menopause Natural Date:
☐ Diaphragm	☐ Menopause Surgical Date:
☐ Oral/Hormonal contraceptives ☐ Oral ☐ Patch ☐ Ring	☐ Vasectomy
Age Menses Started: Age Menopause Started:	Are you sexually active? ☐ Yes ☐ No

PREGNANCY HISTORY			
Total Pregnancies:	Deliveries:	Abortions:	Miscarriages:
ADVANCED DIRECTIVES IN PLACE			
☐ None	☐ Living Will	☐ Durable Power of Attorney	☐ Health Care Proxy ☐ POLST

**********FOR OFFICE USE ONLY**********

Reviewed by Provider: _____ Date: _____

Records Requested for screening by: _____ Date: _____

PSYCHIATRIC MEDICAL SERVICES
AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Please complete this form to allow Adapt Psychiatric Medical Services to request records from your previous providers. Completion of this form is optional and not required to establish care at Adapt Psychiatric Medical Services but will help us provide continued care for the patient.

I authorize:

(Physician Name) (Address and/or Phone/Fax)

to use and disclose specific health information regarding:

(Patient Name) (Date of Birth)

to Adapt Integrated Health Care: **Psychiatric Medical Services**
621 W Madrone St., Roseburg, OR 97470
Fax: 541-440-3554

for the purpose of (check all that apply):

☐ Continuity of Care ☐ Phone Conferencing ☐ Other (specify):

Please include (check all that apply): ☐ Chart Notes ☐ Lab/Path Reports ☐ Radiology Reports ☐ EKG Reports ☐ Diagnostic Testing ☐ Immunization Records ☐ Other, please specify timeframe, diagnosis, or specific reports from date patient was last seen:

If we are requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this authorization or to the extent you signed this authorization as a condition to insurance coverage. To revoke this authorization, please contact our office. Unless revoked earlier or otherwise indicated, this authorization will expire **180 days** from the date of signing.

Please initial each statement of consent.

_____ I consent to the disclosure of my HIV/AIDS information.

_____ I consent to the disclosure of my mental health information.

_____ I consent to the disclosure of my genetic testing information.

_____ I consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description above of how much and what kind of information is to be disclosed.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

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/

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.

continued on next page

Your Rights *continued*

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

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.

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 threat to health or safety.*
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.*

continued on next page

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. You may choose to opt out of participation in an HIE by signing an opt out form. Ask staff to contact the Privacy Officer.	***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.html.**

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: 2/3/2023

This Notice of Privacy Practices applies to all Adapt Integrated Health Care Services, Programs and Sites.

Adapt Health Services Programs 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 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 Oregon OCHIN supplies information technology and related services to Adapt and other OCHIN participants. OCHIN also engages in quality Adapt Oregon 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 Oregon 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.

The personal information may include past, present, and future health information as well as information outlined in 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
PO Box 1121
Roseburg, Oregon 97470
https://www.adaptoregon.org/
Privacy Officer contact number: 541-492-0129

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act I have certain rights to privacy regarding my protected health information. I also understand that Adapt has the right to change its Notice of Privacy Practices from time to time.

This Notice describes in detail how Adapt might use or disclose my protected health information. The Notice also discusses my rights and Adapt's duties with respect to my protected health information. I understand I also have the right to review the Notice before signing this acknowledgement and at any time I may contact Adapt to obtain a current copy in print or electronically, or I may review the current copy online at Adapt's website.

By signing this form, I further acknowledge that medical information collected at Adapt Integrated Health Care will be stored in an electronic medical record system and kept securely in line with state and federal regulations.

_____ _____

Signature of Patient/Guardian or Personal Representative Date

_____ _____

Printed Name of Patient/Guardian or Personal Representative Relationship to Patient

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OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

Adapt Staff Signature:_____

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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**

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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

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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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PRESCRIPTION REFILL POLICY

We are committed to providing excellent health care, and we want to simplify the process to get you the medications you need in a timely manner.

We ask that you:

- **Bring all your medications to each visit, unless told differently by your Provider.**
- **Let the Medical Assistant and Provider know how many refills you will need to last until your next scheduled appointment.**
- **For new medications, ask for enough refills to last until your next appointment.**

When you get your medication refilled at the pharmacy, check to see if you have any refills left. If no refills are left, call us to schedule an appointment with your Provider. In most cases, if you need refills, we will ask you to come for an appointment.

If we cannot get you an appointment before you will run out of your prescription, we will ask that you contact your pharmacy and request that they fax us a refill request. Allow three business days for this process. If your request is on a Friday, your refill may not be ready until the next Wednesday.

You will still need to make an appointment to see your Provider for any more refills.

If you have a Controlled Substance Use Agreement with your provider for controlled medications, follow the requirements of the Agreement. If you do not know the requirements, ask for another copy of your Agreement and discuss it with your Provider at your next appointment.

If you have any questions, please contact us. Thank you for your cooperation.

Winston Clinic 671 SW Main Street Winston, OR 97496 P: 541-492-4550	**Mailing Address** P.O. Box 12 Winston, OR 97496	**Fax Number** 541-492-4553
Roseburg Clinic 621 W Madrone Street Roseburg, OR 97470 P: 541-440-3500	**Mailing Address** P.O. Box 12 Winston, OR 97496	**Fax Number** 541-957-3003

adapt
Integrated Health Care

ACKNOWLEDGEMENT
CONTROLLED SUBSTANCE PRESCRIBING PRACTICES

At Adapt Primary Care, your health and safety are our priority. Because of this, our clinic policies limit the prescribing of controlled substances for chronic conditions. Controlled substances are medications that the federal government more carefully regulates due to the risks of the medications. These medications include, but are not limited to: narcotic pain medications, such as oxycodone and other opioid pain medications; some anti-anxiety medications, such as Xanax; stimulant medications used to treat ADHD, such as Adderall; and even some medications to treat insomnia, such as Ambien. Sometimes medications are added to this list. Although we do sometimes prescribe controlled substances to our patients, we are a primary care clinic, not a specialty care clinic such as pain management. If we cannot meet your needs in primary care, we will work with you on an appropriate referral to a specialist.

As a new patient of Adapt Primary Care, we want to ensure we are providing you with safe and effective care. Before beginning any prescription for a controlled substance, we want to have a good understanding of what is going on for you. To make sure we have time to focus on your concerns, we will schedule a separate appointment to discuss pain, anxiety, or other concerns for which you might be prescribed a controlled substance. That way, your new patient appointment can be focused on understanding your overall health. This means that a controlled substance, including narcotic pain medications, *will not* be prescribed at your new patient appointment. If you are currently prescribed a controlled substance, please work with your current prescriber to continue the medication until after your first *follow-up* appointment with your new Primary Care Provider. Although we try to schedule this as soon as possible, in rare cases this could be several weeks after your first appointment.

After your first appointment at Adapt Primary Care, you will be scheduled for a follow-up appointment where you will be further evaluated by both your Primary Care Provider and one of our behavioral medicine providers. They will work with you to create a plan of care that includes both medication *and* non-medication treatments. This does not guarantee that medications you are currently prescribed will be continued or continued at the same dose. Any time a medication is discontinued, your Primary Care Provider will make sure this is done safely. If a controlled substance is prescribed, it will be only one part of a larger treatment plan.

By scheduling a new patient appointment at Adapt Primary Care, you are showing that you understand our approach to prescribing controlled substances.

Patient or Guardian / Personal Representative signature (circle one)	**Date**
Printed name of Patient	**Printed name of Signatory and relationship, if not Patient**