



Josephine County

**SUBSTANCE USE TREATMENT
NEW PATIENT PACKET**

www.adaptoregon.org

Packet Updated 8/25/23

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

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 <i>Closed Sat & Sun</i>	<i>After-hours answering service (541) 440-3500</i>
Winston Clinic 671 SW Main Street, Winston, OR 97496	(541) 492-4550	Mon–Thu, 7am–6pm Fri, 7am–5pm <i>Closed Sat & Sun</i>	
Mental Health Care			
Roseburg Office 621 W Madrone Street, Roseburg, OR 97470	(541) 440-3532	Mon-Fri, 8am-5pm <i>Closed Sat & Sun</i>	<i>After Hours & Weekends call the 24-Hour Crisis Line (800) 866-9780</i>
Youth & Family Mental Health 548 SE Jackson Street, Roseburg, OR 97470	(541) 229-8434	Mon-Fri, 8am-5pm <i>Closed Sat & Sun</i>	
Psychiatric Services 621 W Madrone, Roseburg, OR 97470	(541) 229-8973	Mon-Fri, 8am-5pm <i>Closed Sat & Sun</i>	
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) 492-0152	Mon-Fri, 8am-5pm <i>Closed Sat & Sun</i>	<i>After Hours & Weekends call the 24-Hour Crisis Line (800) 866-9780</i>
North Bend Office 400 Virginia Ave., Suite 201, North Bend, OR 97459	(541) 751-0357	Mon-Fri, 8am-5pm <i>Closed Sat & Sun</i>	<i>24-Hour Crisis Line (541) 290-3820</i>
Grants Pass Office 356 NE Beacon Drive, Grants Pass, OR 97526	(541) 474-1033	Mon, Tue, Thu, Fri 8am-5pm <i>Closed Wed 1pm-3pm Closed Sat & Sun</i>	<i>24-Hour Crisis Line (541) 472-9983</i>

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 refill, 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).

Patient-Centered Primary Care Home

We are a patient-centered primary care home. Learn more at <https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/index.aspx>.

FTCA Deemed Facility

Our health center receives funding from the U.S. Department of Health and Human Services (HSS) and has deemed status by the U.S. Public Health Service (PHS) with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered persons. Learn more at <https://bphc.hrsa.gov/ftca/about/index.html>.

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
- \$9.00 for DUII Manual
- DUII Referral from ADES and DMV Driving Record
- Court Documents

Appointments: Schedule / Reschedule / Cancellations

Please call Adult Outpatient Services at (541) 474-1033 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

NEW PATIENT-CLIENT REGISTRATION FORM

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):			
<input type="checkbox"/> Home Phone: _____		<input type="checkbox"/> Cell Phone: _____	
<input type="checkbox"/> Message Phone: _____		<input type="checkbox"/> Email: _____	
Patient's Occupation:		Employer:	
Employer's Phone:			
Employment Status (check one): <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal/Temporary <input type="checkbox"/> Self-Employed			
<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled			
Student Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not a Student			
Responsible Party Name (complete if other than patient): _____			
Date of Birth: _____		Social Security #: _____	
Employer: _____		Phone: _____	
INSURANCE INFORMATION (Provide copies of your insurance cards)			
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

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

NEW PATIENT-CLIENT REGISTRATION FORM

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 to M) ☐ Transgender (M to F)
☐ Other ☐ Choose not to disclose ☐ Nonbinary/Gender Queer ☐ Questioning ☐ Two Spirit

Patient's Sex Assigned at Birth (check one): ☐ Female ☐ Male ☐ Intersex ☐ Unknown
☐ 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

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences.

Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Race and Ethnicity

1. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

2. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

Hispanic and Latino/a/x

- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander

- ☐ Chamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White

- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian and Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Black and African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African

- ☐ Middle Eastern
- ☐ North African

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other categories

- ☐ Other (please list) _____
- ☐ Don't know
- ☐ Don't want to answer

3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?

- | | |
|---|--|
| <input type="checkbox"/> Yes. Please circle your primary racial or ethnic identity above. | <input type="checkbox"/> N/A. I only checked one category above. |
| <input type="checkbox"/> I do not have just one primary racial or ethnic identity. | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> No. I identify as Biracial or Multiracial. | <input type="checkbox"/> Don't want to answer |

Language (*Interpreters are available at no charge*)4a. What language or languages do you **use at home**? _____**Skip to question 7 if you indicated English only**4b. In what language do you want us to communicate in **person, on the phone, or virtually** with you?
_____4c. In what language do you want us to **write** to you? _____5a. Do you need or want an **interpreter** for us to communicate with you?☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

- ☐ Spoken language interpreter ☐ Deaf Interpreter for Deaf Blind, additional barriers, or
☐ both American Sign Language interpreter ☐ Contact sign language (PSE) interpreter
☐ Other (*please list*): _____

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

☐ Very Well ☐ Well ☐ Not Well ☐ Not at all ☐ Don't know ☐ Don't want to answer

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential. (**Please write in "don't know" if you don't know when you acquired this condition, or "don't want to answer" if you don't want to answer the question.*)

Yes

***If yes, at what age did this condition begin?**

No

Don't know

Don't want to answer

Don't know what this question is asking

7. Are you **deaf** or do you have **serious difficulty hearing**?☐☐☐☐☐8. Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?☐☐☐☐☐**Please stop now if you/the person is under age 5**9. Do you have **serious difficulty** walking or climbing stairs?☐☐☐☐☐10. Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?☐☐☐☐☐11. Do you have **difficulty dressing or bathing**?☐☐☐☐☐12. Do you have **serious difficulty learning how to do things most people your age can learn**?☐☐☐☐☐13. Using your **usual (customary) language**, do you have **serious difficulty communicating** (*for example understanding or being understood by others*)?☐☐☐☐☐☐**Please stop now if you/the person is under age 15**14. Because of a **physical, mental or emotional condition**, do you have **difficulty doing errands alone** such as visiting a doctor's office or shopping?☐☐☐☐☐15. Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?☐☐☐☐☐☐

Due Date _____

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.**

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

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 (last 4): XXX-XX-____ 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: _____

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**



Client/Patient	Legal Last Name	First	MI	Date of Birth
	Other Names Used by Client/Patient			

I authorize **Adapt Integrated Health Care** to use and disclose my protected health information as described below.

Individual or Entity Authorized to Receive or Use the Protected Health Information:	
Name (Person or Organization):	Address:
	City, State: Zip:
	Phone:
Mutual Exchange: <input type="checkbox"/> Yes <input type="checkbox"/> No Verbal Only: <input type="checkbox"/> Verbal and May Receive Copies from the Chart: <input type="checkbox"/>	

Protected Health Information to be Used and/or Disclosed:			
Check All That Apply:	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Primary Care	<input type="checkbox"/> SUD (42 CFR Part 2 Protected Programs)

Check All That Apply:	
<input type="checkbox"/> All Records Related to Services Checked Above	
-OR SPECIFICALLY-	
<input type="checkbox"/> My name and contact information	<input type="checkbox"/> Laboratory Test Results
<input type="checkbox"/> My status as a client in treatment	<input type="checkbox"/> Discharge Plan
<input type="checkbox"/> Appointment Information & Attendance Reports	<input type="checkbox"/> Date of Discharge & Discharge Status
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Chart/Progress Notes
<input type="checkbox"/> Assessment	<input type="checkbox"/> Treatment Participation and Progress
<input type="checkbox"/> Medications and dosages	<input type="checkbox"/> Behaviors & Concerns
<input type="checkbox"/> Treatment Plan or Summary	<input type="checkbox"/> Recommendations & Management Strategies
<input type="checkbox"/> SUD History Summaries	<input type="checkbox"/> Lab/Path reports
<input type="checkbox"/> EKG Reports	<input type="checkbox"/> Diagnostic Testing
<input type="checkbox"/> Radiology reports	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Other (please be specific):	

If the information to be disclosed contain 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 mark in the applicable space next to the type of information.				
<input type="checkbox"/> Drug/Alcohol Diagnosis, treatment and/or referral	<input type="checkbox"/> Mental Health Information	<input type="checkbox"/> HIV/AIDS Information	<input type="checkbox"/> Genetic Testing Information	<input type="checkbox"/> Sickle Cell Information

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**



Purpose of the Use or Disclosure	
Check all that apply:	
<input type="checkbox"/> Facilitate payment and healthcare operations	<input type="checkbox"/> Care and service coordination
<input type="checkbox"/> Exchange information related to parole, probation, and/or legal status	<input type="checkbox"/> Continuity of Care
<input type="checkbox"/> Exchange information as relates to housing	<input type="checkbox"/> Conferencing and/or consultation
<input type="checkbox"/> Facilitate client transportation	<input type="checkbox"/> Facilitate Treatment
<input type="checkbox"/> Food stamp program, Oregon Health Plan enrollment, and Self-Sufficiency programs	<input type="checkbox"/> To allow a contact person in the case of medical emergency
<input type="checkbox"/> Exchange information related to client's treatment and progress	<input type="checkbox"/> Coordinate education services
<input type="checkbox"/> For myself for my records.	
Other: _____	

Expiration and Revocation
This authorization will expire (complete one):
• On Date: _____
• On occurrence of the following event: _____
*If no expiration date, event, or condition is listed, this consent form will expire one year from the date it is signed.
Right to Revoke: I understand that I may revoke this authorization at any time. I understand that revocation of this authorization will not affect any action Adapt Integrated Health Care took in reliance on this authorization before receiving my notice of revocation. Nor will it affect any information that was already disclosed.

Client Signature	_____	_____
	Signature	Date
	_____	Relationship to Client (check one):
	Printed Name of Client/Patient	<input type="checkbox"/> Patient <input type="checkbox"/> Guardian
		<input type="checkbox"/> Personal Representative Signature*
*If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must also be provided: _____		

Important Information for the Client

To provide or pay for health services: If Adapt Integrated Health Care is acting as a provider of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services **unless** the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. (Examples would be: assessments, tests, or evaluations).

Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This is a Voluntary Form. Adapt Integrated Health Care cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

You are entitled to a copy of this authorization.

This authorization is voluntary and is meant to confirm your directions.

Redisclosure:

For Primary Care and Mental Health Services: I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law.

For SUD Programs: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR 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 CFR 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.

Health Using This Form:

Terms Used: Mutual exchange allows information to go back and forth between Adapt Integrated health Care and the person or organization listed on the authorization.

Assistance: Whenever possible, an Adapt Integrated Health Care staff person should fill out this form with you. Be sure you understand the form before signing. Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an authorized person to sign on your behalf.

Minors: If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information, if you are age 15 or older.

Special Attention: For information about HIV/AIDS, mental health, genetic testing, or alcohol/drug abuse treatment, the authorization must clearly identify the special information that may be disclosed.

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)?				
<input type="checkbox"/> Ativan	<input type="checkbox"/> Dalmane	<input type="checkbox"/> Halcion	<input type="checkbox"/> Prosom	<input type="checkbox"/> Serax
<input type="checkbox"/> Xanax	<input type="checkbox"/> Doral	<input type="checkbox"/> Niravan	<input type="checkbox"/> Restoril	<input type="checkbox"/> Tranxene
If yes, date of last use: _____ Is it a current prescription? <input type="checkbox"/> Yes <input type="checkbox"/> No Prescribed to you? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have any past/present withdrawal symptoms from alcohol or anti-anxiety medication? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Never <input type="checkbox"/> Previous Use <input type="checkbox"/> Current Use If using: <input type="checkbox"/> Smoke <input type="checkbox"/> Smokeless <input type="checkbox"/> Vape				
How much / How often do you use tobacco? _____ Do you have a Medical Marijuana card? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you been in treatment before? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have a history of:				
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Vision Problem	<input type="checkbox"/> Dental Problem		
<input type="checkbox"/> Heart Attack, Stroke, Heart Surgery	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Headaches (frequent/severe)		
<input type="checkbox"/> Seizure	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Chronic Cough		
<input type="checkbox"/> DT's	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Back Injury/Pain		
<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Other Chronic Medical Condition	<input type="checkbox"/> Eating Disorder		
<input type="checkbox"/> Chronic Pain				
If any conditions are checked, please explain: _____				

Any Allergies to: <input type="checkbox"/> Medications <input type="checkbox"/> Bee Stings <input type="checkbox"/> Foods List allergies:			
Have you been diagnosed with: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> HIV If yes, do you need treatment for Hepatitis C / HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, do you want to be tested for Hepatitis C / HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you been tested for TB? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Current TB Card? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Current Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a 30-day supply? <input type="checkbox"/> Yes <input type="checkbox"/> No Need Refill? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic/Anxiety <input type="checkbox"/> Paranoia <input type="checkbox"/> Hallucinations <input type="checkbox"/> Suicidal Thoughts or Plan If you checked suicidal thoughts or plan, please describe:			
Have you ever been diagnosed with a mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever felt the need to bet more and money? <input type="checkbox"/> Yes <input type="checkbox"/> No			
LEGAL STATUS			
<input type="checkbox"/> Parole <input type="checkbox"/> Probation <input type="checkbox"/> Mental Health Court <input type="checkbox"/> Drug Court <input type="checkbox"/> Incarcerated <input type="checkbox"/> None <input type="checkbox"/> Other:			
Do you have any Pending Court Cases? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what?			
Do you have any current or previous charges for Violent Offense? <input type="checkbox"/> Yes <input type="checkbox"/> No Sexual Offense: <input type="checkbox"/> Yes <input type="checkbox"/> No			
How many times have you been arrested for DUII?		Other charges?	
Check agencies you're involved with: <input type="checkbox"/> Mental Health <input type="checkbox"/> Voc Rehab <input type="checkbox"/> Bay Cities <input type="checkbox"/> Translink <input type="checkbox"/> CWP			
Child Welfare Case Worker:		Parole/Probation Officer:	
Do you have any Family or Friends who work for Adapt Integrated Health Care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list name(s) and department:			

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

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

LIFE EVENTS CHECKLIST

Patient's Name:	Date of Birth:
<p>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 <u>happened to you</u> personally, (b) you <u>witnessed it</u> happen to someone else, (c) it <u>doesn't apply</u> to you.</p> <p style="text-align: center;">Be sure to consider your <u>entire life</u> (growing up as well as adulthood) as you go through the list of events.</p>	

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

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Within the last 30 days, have you had any of the following symptoms <u>lasting for more than 2 weeks</u> ?	
<input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Night Sweats (so bad that you had to change your clothes/sheets) <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss (unintentional) <input type="checkbox"/> Productive Cough <input type="checkbox"/> Diarrhea (lasting more than 1 week) <input type="checkbox"/> Women—Have you missed your last two periods <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Lumps/swollen gland in neck or armpit	
3. Have you ever been told you have TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has anybody you know or have lived with been diagnosed with TB in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been treated for TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever been told that you have: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C	
8. Do you use needles to shoot drugs or shared needles or syringes to inject drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever had a job that put you in danger of needle stick injuries or other types of blood contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you use stimulants (cocaine/methamphetamine)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Did you have a blood transfusion before 1992 or received blood products produces before 1987 for clotting problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Was your birth mother infected with Hepatitis C virus during the time of your birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you been, or are you currently, on long term dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you had sex with someone who has the blood disease hemophilia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Have you had unprotected sex with a person who injects drugs or with a man who has sex with other men?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Have you had sex in exchange for money or drugs, or to survive?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Have you ever injected drugs, even once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Have you ever been pricked by a needle or syringe that may have been infected with HIV or Hepatitis C Virus?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, would you like a blood test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, have you been tested within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever had a blood test for the Hepatitis C Virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, would you like a blood test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, have you been tested within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. How would you judge your own risk for being infected with HIV (the AIDS virus)? <input type="checkbox"/> I know I am infected. <input type="checkbox"/> I think I am at NO risk. <input type="checkbox"/> I think I am at high risk. <input type="checkbox"/> I am not sure what my risk is. <input type="checkbox"/> I think I am at low risk.	
4. How would you judge your own risk for being infected with the Hepatitis C Virus? <input type="checkbox"/> I know I am infected. <input type="checkbox"/> I think I am at NO risk. <input type="checkbox"/> I think I am at high risk. <input type="checkbox"/> I am not sure what my risk is. <input type="checkbox"/> I think I am at low risk.	

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.

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.

Medical Scribe Service

I understand that a professional medical scribe service may be used during my visit to assist my provider(s) with documentation at no cost to me. I understand that the scribe service may be virtual. I also understand that the medical scribe service follows a professional code of ethics that ensures that all medical information discussed with my provider(s) and other clinic staff will be kept confidential.

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/>



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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none">• We can share health information about you for certain situations such as:<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• We can use or share your information for health research.
Comply with the law	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• We can use or share health information about you:<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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

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

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: _____

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	<i>Initial Below</i>	<i>Initial Below</i>

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

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**