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Integrated Health Care

Psychiatric Medical Services

ADULT NEW PATIENT PACKET

Packet Updated 01/01/24

An Oregon leader in patient-centered primary care, behavioral health care, and prevention.

www.adaptoregon.org

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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 & Sun*	*After Hours & Weekends call the 24-Hour Crisis Line (800) 866-9780*
Youth & Family Mental Health 548 SE Jackson Street, Roseburg, OR 97470	(541) 229-8434	Mon-Fri, 8am-5pm *Closed Sat & Sun*	
Psychiatric Services 621 W Madrone, Roseburg, OR 97470	(541) 229-8973	Mon-Fri, 8am-5pm *Closed Sat & Sun*	
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 & Sun*	*After Hours & Weekends call the 24-Hour Crisis Line (800) 866-9780*
Reedsport Office 680 Fir Street, Reedsport, OR 97467	(541) 751-0357	By Appointment	

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.

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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.

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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

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ADULT NEW PATIENT/CLIENT REGISTRATION

PATIENT INFORMATION			
Last Name:	**First Name**:	**Middle Initial**:	**Preferred Name**:
Date of Birth:	**Age**:	**Last Name at Birth**:	
Social Security #:	**Driver's License #**:		
Home Address:	**City**:	**State**:	**Zip**:
Mailing Address *(if different):*	**City**:	**State**:	**Zip**:

Phone *(please check your primary phone)*:

☐ Home Phone: _____ ☐ Cell Phone: _____

☐ Message Phone: _____ ☐ Email Address:_____

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

Patient's Legal Guardian or Representative: If patient has a legal guardian or representative, please provide that information (*proof required if legal guardian, representative, or medical power of attorney, etc.).*

Legal Guardian or Representative Name: _____ **Date of Birth**:_____

Social Security #: _____ **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:

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Name of Secondary Insurance *(if applicable):*	
Group #:	Policy #:
Policyholder (PH) Name:	PH Date of Birth:
PH Social Security #:	PH Relationship to Patient:

PATIENT/CLIENT INFORMATION

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. All information disclosed in this section will not impact your access to care or any government programs you may participate in.

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

Are you Homeless / Unhoused? ☐ Yes ☐ No

If Yes, please specify: ☐ At risk for homeless ☐ Child at risk for homeless
☐ Currently not homeless (was homeless in last 12 mo) ☐ Homeless unknown shelter ☐ Living in shelter
☐ Living with others ☐ Permanent supportive housing ☐ Single occupancy hotel ☐ Street, camp, bridge
☐ Transitional housing ☐ Veteran at risk for homeless

Patient Housing Status: ☐ Vehicle ☐ Unstable ☐ Temporary ☐ Stable/Permanent
☐ Recovery Center ☐ Other

Public Housing (Section 8/HUD): ☐ Yes ☐ No

Migrant / Seasonal: ☐ Migrant ☐ Seasonal ☐ Neither

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:

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ADDITIONAL PATIENT INFORMATION *(please answer all questions)*
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
Pronouns *(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

FAMILY / HOUSEHOLD INCOME

Please check the correct amount of your monthly household income:

Number of People in Household, including patient	**1**	**2**	**3**	**4**	**5**	**6**
Household income is less than	☐ 1,519	☐ 2,054	☐ 2,590	☐ 3,125	☐ 3,660	☐ 4,196
Household income is less than	☐ 1,823	☐ 2,465	☐ 3,108	☐ 3,750	☐ 4,393	☐ 5,035
Household income is less than	☐ 2,126	☐ 2,876	☐ 3,625	☐ 4,375	☐ 5,125	☐ 5,874
Household income is less than	☐ 2,430	☐ 3,287	☐ 4,143	☐ 5,000	☐ 5,857	☐ 6,713
Household Income is above all amounts listed, please check the box for your household size	☐	☐	☐	☐	☐	☐

If there are more than 6 people in your household, how many people are in your household? _____

What is your monthly household income? _____

☐ I choose not to provide my financial information.

_____ _____ _____

Patient Signature **Parent/Legal Guardian Signature** **Date**

Print Name / Relationship to Patient: _____

* In the event a legal representative other than a parent of minor child signs this Authorization, a documentation of legal authority must be attached (e.g., Health Care Power of Attorney or Notarized Health Care Representative form).

Oregon Health Authority
Oregon Department of Human Services

Race, Ethnicity, Language, and Disability (READL)

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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?
- ☐ Yes. Please circle your primary racial or ethnic identity above.
- ☐ I do not have just one primary racial or ethnic identity.
- ☐ No. I identify as Biracial or Multiracial.
- ☐ N/A. I only checked one category above.
- ☐ Don't know
- ☐ Don't want to answer

Continue to Page 2

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

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**?						

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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.**

- ☐ 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 Optional (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

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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: ☐ **Yes** ☐ **No** **Verbal Only:** ☐ **Verbal and May Receive Copies from the Chart:** ☐	

Protected Health Information to be Used and/or Disclosed:			
Check All That Apply:	☐ Mental Health	☐ Primary Care	☐ SUD (42 CFR Part 2 Protected Programs)

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

____ Drug/Alcohol Diagnosis, treatment and/or referral	**____Mental Health Information**	**____HIV/AIDS Information**	**____Genetic Testing Information**	**____Sickle Cell Information**

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

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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Purpose of the Use or Disclosure Check all that apply:	
☐ Facilitate payment and healthcare operations	☐ Care and service coordination
☐ Exchange information related to parole, probation, and/or legal status	☐ Continuity of Care
☐ Exchange information as relates to housing	☐ Conferencing and/or consultation
☐ Facilitate client transportation	☐ Facilitate Treatment
☐ Food stamp program, Oregon Health Plan enrollment, and Self-Sufficiency programs	☐ To allow a contact person in the case of medical emergency
☐ Exchange information related to client's treatment and progress	☐ Coordinate education services
☐ 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
	_____ Printed Name of Client/Patient	Relationship to Client (check one): ☐ Patient ☐ Guardian ☐ 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: _____		

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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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 ot 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.

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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
- ☐ 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
- ☐ Other

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

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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: _____

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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.

Notice of Privacy Practices

I understand that it is Adapt's policy to offer patients a printed copy and chance to review the HIPAA Notice of Privacy Practices.

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.

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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.

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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 Signature	**Parent/Legal Guardian Signature**	**Date**

Print Name / Relationship to Patient: _____

* In the event a legal representative other than a parent of minor child signs this Authorization, a documentation of legal authority must be attached (e.g., Health Care Power of Attorney or Notarized Health Care Representative form.

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ADULT COMMUNICATION PERMISSIONS

Full Legal Name of Patient:	**Date of Birth:**

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. In some situations, it may be necessary and appropriate for us to discuss your Protected Health Information with other individuals.

Adapt Integrated Health Care may leave voicemail for the following purposes *(check all that apply)*

☐ General information regarding your care ☐ Billing ☐ **NO** messages of any kind

Phone Number to Use: ☐ Preferred number on file **ONLY** ☐ Other Number: ______________________

Let us know who we may communicate with regarding your care and specify what type of information we may share *(check all that apply)*

______________ ______________ ______________
Contact Name **Relationship** **Phone Number**

☐ Discuss ALL information (this is not authorization to release records)
☐ Appointment management
☐ Pick up items from clinic, including medications, hard copy prescriptions, correspondence, etc.
☐ Other (specify): ______________________

______________ ______________ ______________
Contact Name **Relationship** **Phone Number**

☐ Discuss ALL information (this is not authorization to release records)
☐ Appointment management
☐ Pick up items from clinic, including medications, hard copy prescriptions, correspondence, etc.
☐ Other (specify): ______________________

______________ ______________ ______________
Contact Name **Relationship** **Phone Number**

☐ Discuss ALL information (this is not authorization to release records)
☐ Appointment management
☐ Pick up items from clinic, including medications, hard copy prescriptions, correspondence, etc.
☐ Other (specify): ______________________

The Authorization may be changed or revoked in writing at any time. It will remain in effect until that time. By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient.

______________ ______________ ______________
Patient Signature **Parent/Legal Guardian Signature** **Date**

Print Name / Relationship to Patient: ______________________

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CONSENT TO RECEIVE VOICEMAIL, EMAIL OR TEXT MESSAGES

Patient Name:	**Date of Birth**:

With a patient's consent, healthcare providers may communicate with patients by voicemail, email or text message. Communication that contains Protected Health Information (PHI) requires the patient to sign an authorization form to receive or opt out of receiving information by voicemail, email or text message.

IMPORTANT NOTICE: Communicating through voicemail, email or text message may lead to unintended consequences. Private information, or PHI may be seen by people who you do not want to see it. The transmission of patient information by email and/or texting has risks that patients should consider prior to the use of voicemail, email and/or text messaging. These include, but are not limited to, the following risks:

- Voicemail, email, or text messages are often displayed or recorded automatically and you may not be nearby to monitor the device—a person could hear or 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 texts or listen to voicemail messages.
- If you choose not to use a secure mobile app for text messages, you may be putting your confidentiality and privacy at risk.

By signing below, I understand that Adapt Integrated Health Care has my permission to contact me in the manner described herein, including text message reminders for upcoming appointments. I acknowledge that I have been advised of some of the possible risks of voicemail, email and text messaging, and I will hold Adapt harmless for any disclosures that occur because of these methods of communication. I also understand that I can opt out of receiving text message auto-call appointment reminders at any time by texting STOP to the text message and notifying Adapt by filling out the "Opt Out" section below. If I am signing this document on behalf of another person, I acknowledge that I am consenting or opting out on behalf of the patient.

_____ _____ _____

Patient Signature **Parent/Legal Guardian Signature** **Date**

Print Name / Relationship to Patient: _____

* In the event a legal representative other than a parent of minor child signs this Authorization, a documentation of legal authority must be attached (e.g., Health Care Power of Attorney or Notarized Health Care Representative form.

OPT OUT OF RECEIVING VOICEMAIL, EMAIL OR TEXT MESSAGES

By signing below, I am notifying Adapt Integrated Health Care that I decline to receive automated calls and/or messages at my phone number and/or email for the purpose of appointment reminders, clinic closures, and other matters regarding my health care.

_____ _____

Patient/Legal Guardian Signature **Date**

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INFORMED CONSENT FOR TELEHEALTH SERVICES

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

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.

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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 Adapt 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 Signature **Parent/Legal Guardian Signature** **Date**

Print Name / Relationship to Patient: _____

* In the event a legal representative other than a parent of minor child signs this Authorization, a documentation of legal authority must be attached (e.g., Health Care Power of Attorney or Notarized Health Care Representative form).