

# **MENTAL HEALTH**

## **PEDIATRIC NEW PATIENT PACKET**

*Packet Updated 01/01/25*

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

*[www.adaptoregon.org](http://www.adaptoregon.org)*

## **Welcome to Adapt Integrated Health Care!**

Thank you for giving us an opportunity to partner with you on your journey to good health. We look forward to meeting you at your first visit to our office.

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. We look forward to serving you.

*Your Adapt Integrated Health Care Team*

P.S. Visit our website at [www.AdaptOregon.org](http://www.AdaptOregon.org) to learn more about us!

## CLINIC LOCATIONS, PHONE NUMBERS & HOURS

	Phone	Hours	After Hours
<b>Patient-Centered Primary Care</b>			
<b>Roseburg Primary Care &amp; Behavioral Medicine</b> 621 W Madrone Street, Roseburg, OR 97470	(541) 440-3500	Mon–Thu, 7am–6pm Fri, 7am–5pm Closed Sat & Sun	<i>After-hours            answering service            (541) 440-3500</i>
<b>Winston Primary Care &amp; Behavioral Medicine</b> 671 SW Main Street, Winston, OR 97496	(541) 492-4550		
<b>Mental Health Care</b>			
<b>Coos County</b> 400 Virginia Ave., Suite 201, North Bend, OR 97459	(541) 751-0357	Mon-Fri, 8am-5pm Closed Sat & Sun	<i>24-Hour Crisis Line            (541) 266-6800</i>
<b>Curry County</b> 615 5th St., Brookings, OR 97415 29845 Airport Way, Gold Beach, OR 97444 1403 Oregon St., Port Orford, OR 97465 ( <i>por cita</i> )	(877) 408-8941	Mon-Fri, 8am-5pm Closed 12-1 for Lunch Closed Sat & Sun	<i>24-Hour Crisis Line            ( 877) 519-9322</i>
<b>Douglas County</b> 621 W Madrone Street, Roseburg, OR 97470	(541) 440-3532	Mon-Fri, 8am-5pm Closed Sat & Sun	<i>After Hours &amp;            Weekends call the            24-Hour Crisis Line            (800) 866-9780</i>
<b>Psychiatric Medical Services</b> 621 W Madrone, Roseburg, OR 97470	(541) 229-8973		
<b>Substance Use Treatment</b>			
<b>Coos County</b> 400 Virginia Ave., Suite 201, North Bend, OR 97459	(541) 751-0357	Mon-Fri, 8am-5pm Closed Sat & Sun	<i>24-Hour Crisis Line            (541) 266-6800</i>
<b>Curry County</b> 615 5th St., Brookings, OR 97415 29845 Airport Way, Gold Beach, OR 97444 1403 Oregon St., Port Orford, OR 97465 ( <i>por cita</i> )	(877) 408-8941	Mon-Fri, 8am-5pm Closed 12-1 for Lunch Closed Sat & Sun	<i>24-Hour Crisis Line            (877) 519-9322</i>
<b>Douglas County</b> 621 W Madrone Street, Roseburg, OR 97470 680 Fir Street, Reedsport, OR 97467 ( <i>by appt only</i> )	(541) 492-0152	Mon-Fri, 8am-5pm Closed Sat & Sun	<i>After Hours &amp;            Weekends call the            24-Hour Crisis Line            (800) 866-9780</i>
<b>Josephine County</b> 356 NE Beacon Drive, Grants Pass, OR 97526	(541) 474-1033	Mon, Tue, Thu, Fri 8am-5pm Closed Wed 1pm-3pm Closed Sat & Sun	<i>24-Hour Crisis Line            (541) 474-5360</i>

## NEW PATIENT INFORMATION

### Patient Portal

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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

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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

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

### Sliding Fee & Discount Application

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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

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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

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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](https://www.ada.gov/service_animals_2010.htm)).

### Patient-Centered Primary Care Home

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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

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Our health center receives funding from the U.S. Department of Health and Human Services (HHS) 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 Mental Health Visit

It's said that a thousand mile journey starts with the first step. As the Community Mental Health Program and a mental health service provider for Coos County, we are committed to improving access to the highest quality treatment and support services. Our skilled team of psychiatrists, psychiatric nurse practitioners, nurses and licensed mental health professionals will work with you to gain the skills and resources needed to be successful at home, work and in the community.

### Who We Serve

We provide comprehensive mental health care for children, adolescents, adults, and families. Mental Health Services are provided to all Coos County residents.

### How to Prepare for Your First 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
- Be prepared to discuss your top health concerns with your provider; follow-up appointments may be scheduled following your initial visit

### Our Mental Health Services

#### Douglas County 24/Hour Crisis Line

- Monday-Friday, 8am to 5pm  
(541) 440-3532
- After Hours & Weekends  
1-(800)-866-9780

#### Coos County 24/Hour Crisis Line

- Monday-Friday, 8am to 5pm  
(541) 751-0357
- After Hours & Weekends  
(541) 266-6800

#### Curry County 24/Hour Crisis Line

- Monday-Friday, 8am to 5pm  
(877) 408-8941
- After Hours & Weekends  
(877) 519-9322

#### Adult Outpatient

- Individual and Group Counseling

#### Youth & Family Services

- Individual and Group Counseling
- Intensive In-Home Behavioral Health
- School-Based Therapeutic Services
- Wraparound Program
- Healthy Transitions

#### Community Support Services

- Assertive Community Treatment
- Case Management
- CHOICE Model
- Early Assessment & Support Alliance
- Forensic Mental Health Services
- IPS Supported Employment
- Peer Support Services

*Contact your nearest Adapt Integrated Health Care office to find out about the programs and services available in your location.*

## PEDIATRIC NEW PATIENT REGISTRATION

PATIENT INFORMATION			
Last Name:	First Name:	Middle Initial:	Preferred Name:
Date of Birth:	Age:	Last Name at Birth:	
Social Security #:			
Home Address:	City:	State:	Zip:
Mailing Address (if different):	City:	State:	Zip:
<b>Phone (please check your primary phone):</b> <input type="checkbox"/> Home Phone: _____ <input type="checkbox"/> Cell Phone: _____ <input type="checkbox"/> Message Phone: _____ <input type="checkbox"/> Email: _____			
<b>Student Status:</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not a Student			
PARENT / GUARDIAN INFORMATION			
Mother's Name:	Date of Birth:	Phone:	
Father's Name:	Date of Birth:	Phone:	
<b>Patient's Legal Guardian or Representative if different than above:</b> If patient has a legal guardian or representative, please provide that information ( <i>proof required if legal guardian, representative, or medical power of attorney, etc.</i> ).			
Legal Guardian or Representative Name: _____		Date of Birth: _____	
Social Security #: _____		Phone: _____	
Name of person patient primarily lives with: _____			
Relationship to patient: _____		Phone: _____	
RESPONSIBLE PARTY WHO HAS FINANCIAL RESPONSIBILITY FOR THE PATIENT			
Responsible Party Name:		Date of Birth:	
Social Security #:		Phone:	
Address:	City:	State:	Zip:

<b>INSURANCE INFORMATION</b> <i>(Provide copies of your insurance cards)</i>	
<b>Name of Primary Insurance:</b>	
Group #:	Policy #:
Policyholder (PH) Name:	PH Date of Birth:
PH Social Security #:	PH Relationship to Patient:
<b>Name of Secondary Insurance</b> <i>(if applicable):</i>	
Group #:	Policy #:
Policyholder (PH) Name:	PH Date of Birth:
PH Social Security #:	PH Relationship to Patient:
<b>Please tell us if any of the following apply to the patient</b> <i>(mark all that apply):</i>	
<input type="checkbox"/> Patient is a current employee of Adapt. <input type="checkbox"/> Patient's immediate family member is an employee of Adapt. <input type="checkbox"/> Patient has a close relationship with an Adapt employee.	
<i>If you marked any of the statements, please provide the employee's name and department.</i>	
Employee Name: _____	Department: _____
Employee Name: _____	Department: _____
<b>Referral Source:</b> <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	
<b>PATIENT/CLIENT INFORMATION</b>	
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.	
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
<b>Dependent Child of Veteran?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Are you Homeless / Unhoused?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If Yes, please specify:</b> <input type="checkbox"/> At risk for homeless <input type="checkbox"/> Child at risk for homeless <input type="checkbox"/> Currently not homeless (was homeless in last 12 mo) <input type="checkbox"/> Homeless unknown shelter <input type="checkbox"/> Living in shelter <input type="checkbox"/> Homeless living temporarily with others <input type="checkbox"/> Permanent supportive housing <input type="checkbox"/> Single occupancy hotel <input type="checkbox"/> Street, camp, bridge <input type="checkbox"/> Transitional housing	
<b>Patient Housing Status:</b> <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	
<b>Public Housing (Section 8/HUD):</b> <input type="checkbox"/> Yes <input type="checkbox"/> 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):

**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  Omniseual  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**

**Check the amount closest to your monthly household income for the total number of people in your household:**

<b>Number of People in Household</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Household income is less than	<input type="checkbox"/> 1,568	<input type="checkbox"/> 2,129	<input type="checkbox"/> 2,689	<input type="checkbox"/> 3,250	<input type="checkbox"/> 3,810	<input type="checkbox"/> 4,370
Household income is less than	<input type="checkbox"/> 1,882	<input type="checkbox"/> 2,555	<input type="checkbox"/> 3,227	<input type="checkbox"/> 3,900	<input type="checkbox"/> 4,572	<input type="checkbox"/> 5,245
Household income is less than	<input type="checkbox"/> 2,196	<input type="checkbox"/> 2,980	<input type="checkbox"/> 3,765	<input type="checkbox"/> 4,550	<input type="checkbox"/> 5,334	<input type="checkbox"/> 6,119
Household income is less than	<input type="checkbox"/> 2,510	<input type="checkbox"/> 3,406	<input type="checkbox"/> 4,303	<input type="checkbox"/> 5,200	<input type="checkbox"/> 6,096	<input type="checkbox"/> 6,993
Household Income is above all amounts listed, please check the box for your household size	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)



## MENTAL HEALTH SUPPLEMENTAL CLIENT REGISTRATION

<b>CLIENT INFORMATION</b>		
<b>Client Full Legal Name:</b>		
_____	_____	_____
<b>First Name</b>	<b>Middle Initial</b>	<b>Last Name</b>
<b>Date of Birth:</b>		
<b>CLIENT HEALTH INFORMATION</b>		
<b>Currently Pregnant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Number of child dependents under 18 in household:</b>		
<b>Current Tobacco Use:</b> <input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current If Current, how much per day:		
<b>Type of Tobacco Use:</b> <input type="checkbox"/> Cigarette <input type="checkbox"/> Cigar <input type="checkbox"/> Smokeless (chew) <input type="checkbox"/> Vape <input type="checkbox"/> Pipe		
<b>Have you tried to quit?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Quit method used (e.g., gum, patch):		
<b>Passive smoke exposure?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Name of Patient's Primary Care Provider:</b>		
<b>CLIENT LEGAL INFORMATION</b>		
<b>Client's Legal Information:</b> <input type="checkbox"/> Parole <input type="checkbox"/> Probation <input type="checkbox"/> Incarcerated <input type="checkbox"/> Mental Health Court <input type="checkbox"/> PSRB		
<input type="checkbox"/> JPSRB <input type="checkbox"/> Civil Commitment <input type="checkbox"/> Other ( <i>please specify</i> ):		
<b>Client's Number of Arrests in Past Month:</b>	<b>Total Arrests:</b>	<b>Total DUII Arrests:</b>

\_\_\_\_\_  
**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).

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
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7. Are you **deaf** or do you have **serious difficulty hearing**?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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8. Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**Please stop now if you/the person is under age 5**

9. Do you have **serious difficulty** walking or climbing stairs?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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10. Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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11. Do you have **difficulty dressing or bathing**?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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12. Do you have **serious difficulty learning how to do things most people your age can learn**?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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13. Using your **usual (customary) language**, do you have **serious difficulty communicating** (*for example understanding or being understood by others*)?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**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?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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15. Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**FINANCIAL DISCOUNT APPLICATION INFORMATION**

**Please retain this page for your reference.**

**Complete the next page and return it to Adapt by the due date if you wish to apply.**

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

- Please complete this entire form and provide all requested documents to be considered for a sliding scale discount. Discounts will only be given to patients who qualify and provide verification.
- You have **14 days from the date of service** to complete and return this form to be considered for a discount on your visit. Otherwise, your discount will begin on the date it is returned.
- Adapt will not back date discounts.
- Once your application has been processed, you will receive a letter in the mail notifying you of the discount that you are eligible for.
- All discounts will be valid for one year at which time you will be asked to provide current verification. **If your financial or living circumstances change before this date, you are required to notify Adapt.** This information may adjust your discount.
- If applicable, information provided on this application may be used to determine if you qualify for a discount on services provided by Mercy Outpatient Lab & Imaging ordered by Adapt Primary Care. To be considered for a discount from CHI Mercy Health, you must have applied for Oregon Health Plan. Information on this form may be requested by CHI Mercy Health and will be provided to them for auditing purposes.

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

- |  |   |   |
|--|---|---|
| <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 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
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<b>Name</b>						
-------------	--	--	--	--	--	--

<b>Date of Birth</b>						
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<b>Relationship to Patient</b>	SELF					
--------------------------------	------	--	--	--	--	--

<b>Gross Monthly Income from the following:</b>	<b>Please provide supporting documentation for each source of income listed.</b>					
---	--	--	--	--	--	--

Salary/Wages	\$	\$	\$	\$	\$	\$
--------------	----	----	----	----	----	----

Unemployment	\$	\$	\$	\$	\$	\$
--------------	----	----	----	----	----	----

Social Security	\$	\$	\$	\$	\$	\$
-----------------	----	----	----	----	----	----

Disability	\$	\$	\$	\$	\$	\$
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Pension	\$	\$	\$	\$	\$	\$
---------	----	----	----	----	----	----

Retirement	\$	\$	\$	\$	\$	\$
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Child Support	\$	\$	\$	\$	\$	\$
---------------	----	----	----	----	----	----

Worker's Comp	\$	\$	\$	\$	\$	\$
---------------	----	----	----	----	----	----

Sale of Goods	\$	\$	\$	\$	\$	\$
---------------	----	----	----	----	----	----

Other _____	\$	\$	\$	\$	\$	\$
-------------	----	----	----	----	----	----

<b>TOTAL</b>	\$	\$	\$	\$	\$	\$
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**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:** \_\_\_\_\_

<b>*****FOR OFFICE USE ONLY*****</b>	
Application Date: _____	Expiration Date: _____
<input type="checkbox"/> <b>Based on the information provided, the above listed patient is eligible for a _____% discount.</b>	
<input type="checkbox"/> <b>Based on the information provided, the patient is <u>not</u> eligible for a discount at this time.</b>	
Information verified by: <input type="checkbox"/> Pay Stubs <input type="checkbox"/> Tax Return <input type="checkbox"/> Other _____	
Staff member completing form: _____	Date: _____

## PATIENT ACKNOWLEDGEMENT AND CONSENT OF AGENCY POLICIES

### **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/AI Scribe Service (Scribe Services)**

I understand that a professional medical scribe or AI scribe service (scribe services) 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 services follow a professional code of ethics that ensures that all medical information discussed with my provider(s) and other clinic staff will be kept confidential.

### **Telehealth Services**

Your provider may offer telehealth visits. Telehealth visits are performed securely within the protected electronic medical record environment. You may decline participation in an individual telehealth visit by informing the person scheduling your appointment that you do not wish to have a telehealth visit. Some providers and services may only be available via telehealth. The visit is documented in the electronic medical record in the same way an in-person visit is documented.

### **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 with Adapt 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.

#### **Fee Based Charges for Civil Subpoenas**

For subpoenas issued for a civil matter, Adapt will invoice the attorney or other requester (plaintiff or respondent) a flat rate of \$1000 per clinician per day. An invoice should be provided to the requester and should be paid prior to the appearance date. Waivers such as those for income considerations can be considered on a case by case basis.

#### **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.

#### **Phone Messages, Texting, and Emailing**

We may contact you about your healthcare using the phone numbers and email addresses that you provide us. This may include using an automated phone dialing system, pre-recorded or synthetic voice messages, texting, or email. When we contact you in this manner, you will be given the opportunity to opt out of receiving similar communications going forward. Our messages may include, but are not limited to, information about appointment reminders, discharge planning, billing, prescription reminders, research opportunities, our products and services, treatment alternatives, your general health, and regulatory notices provided in lieu of first-class mail. Because texts and emails are not encrypted, there is a risk that someone else could read or access these messages. We therefore take steps to limit the amount of protected health information that they contain. If you do not wish to receive these types of text or email messages, please let us know, and we will have you sign our opt out form. You may also opt out from receiving text messages from Adapt at any time by replying STOP to any text message received.

#### **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 Adapt 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.

#### **Voter Registration**

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

### **Notice of Privacy Practices**

I understand that it is Adapt 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 policy to offer patients a printed copy and chance to review the following upon admission to any of Adapt state certified behavioral health programs:

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

### **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:**

A written consent to use or disclose records for treatment, payment, or health care operations may be subject to redisclosure by the recipient and no longer protected by this part.

This consent cannot be combined with a consent for use and disclosure of records (or testimony relating information contained in a record) in a civil, criminal, administrative, or legislative investigation or proceeding.

### **Help 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.

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, including my substance use treatment information as part of the single consent for treatment, payment, and health care operations.

**Print Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Parent/Legal Guardian Signature**

\_\_\_\_\_  
**Date**

\*In the event a legal representative other than a parent of a 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).

**OFFICE USE ONLY**

We attempted to obtain written acknowledgement of our Notice of Privacy Practices and other agency policies on this document, 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: \_\_\_\_\_

## CONSENT FOR TREATMENT WITH ROI FOR TREATMENT, PAYMENT AND OPERATIONS SHARING

### 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.

### Release of Information & Single Consent for Treatment, Payment, and Healthcare Operations

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 as part of a substance use treatment program, by signing below, I authorize **Adapt Integrated Health Care** to use and disclose my protected health information, *including all records and all records from a substance use treatment program*, with my **treating providers, health plans, third party payers, and people helping to operate this program** for the purpose of treatment payment and health care operations.

#### *Disclosure*

Any records that are disclosed under this consent may be further disclosed by that entity without your written consent, to the extent the HIPAA regulations permit such disclosure.

#### *Expiration*

This consent acts as a mutual exchange of information to and from afore mentioned entities. This single consent authorization for all uses and disclosures for treatment, payment, and health care operations may be updated as needed by the organization at which time a new signature will be required. This consent ends when the close of provision of services and all required programmatic communications and care coordination have been completed.

*Right to Revoke*

I understand that I may revoke this authorization **in writing** 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.

**Print Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Parent/Legal Guardian  
Signature**

\_\_\_\_\_  
**Date**

\*In the event a legal representative other than a parent of a 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).

## PEDIATRIC COMMUNICATION PERMISSIONS

<b>Full Legal Name of Patient:</b> _____	<b>Date of Birth:</b> _____
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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.

Biological or Legal Guardian Contact Information (please provide proof of legal guardian, legal representative, power of attorney, etc.)	
<b>Name:</b> _____ <b>Relationship:</b> _____ <b>Phone:</b> _____ <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work _____	<b>Name:</b> _____ <b>Relationship:</b> _____ <b>Phone:</b> _____ <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work _____
Adapt Integrated Health Care may leave voicemail for the following purposes (check all that apply)	
<input type="checkbox"/> General information regarding the patient's care <input type="checkbox"/> Billing <input type="checkbox"/> <b>NO</b> messages of any kind	

<b>Patient Contact Information (if applicable):</b> Patients who are minors (under age 18) may request certain levels of confidentiality and consent to various health care matters depending on their age. Further details regarding this can be provided by Adapt Integrated Health Care staff.
<b>Patient's Phone Number:</b> _____ <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work _____

Please complete this section if there is anyone besides the parent/guardian that may regularly seek and authorize health care for the patient AND/OR with whom an Adapt Integrated Health Care representative may share health care information about the patient (e.g., stepparents, grandparents). <i>NOTE: This is not an authorization to release medical records.</i>		
<b>Contact Name</b> _____	<b>Relationship</b> _____	<b>Phone Number</b> _____
Please check all that apply:		
<input type="checkbox"/> Discuss ALL information (this is not authorization to release records)		
<input type="checkbox"/> Appointment Management		
<input type="checkbox"/> Pick up items from clinic, including medications, hard copy prescriptions, correspondence, etc.		
<input type="checkbox"/> Other (specify): _____		

<b>Contact Name</b> _____	<b>Relationship</b> _____	<b>Phone Number</b> _____
<input type="checkbox"/> Discuss ALL information (this is not authorization to release records)		
<input type="checkbox"/> Appointment Management		
<input type="checkbox"/> Pick up items from clinic, including medications, hard copy prescriptions, correspondence, etc.		
<input type="checkbox"/> Other (specify): _____		

The Authorization may be changed or revoked in writing at any time. It will remain in effect until that time or the patient turns 18. 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.

_____	_____	_____
<b>Patient Signature</b>	<b>Parent/Legal Guardian Signature</b>	<b>Date</b>
<b>Print Name / Relationship to Patient:</b> _____		