adapt
Integrated Health Care

MENTAL HEALTH

ADULT NEW PATIENT PACKET

Packet Updated 01/01/25

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

www.adaptoregon.org

adapt
Integrated Health Care

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 to learn more about us!

adapt
Integrated Health Care

CLINIC LOCATIONS, PHONE NUMBERS & HOURS

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

adapt
Integrated Health Care

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.

adapt
Integrated Health Care

ADULT NEW PATIENT REGISTRATION

PATIENT INFORMATION			
Last Name:	**First Name**:	**Middle Initial**:	**Preferred Name**:

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

adapt
Integrated Health Care

Please tell us if any of the following apply to the patient *(mark all that apply):*

☐ Patient is a current employee of Adapt.

☐ Patient's immediate family member is an employee of Adapt.

☐ Patient has a close relationship with an Adapt employee.

If you marked any of the statements, please provide the employee's name and department.

Employee Name: _____ Department: _____

Employee Name: _____ Department: _____

Referral Source: ☐ Outreach Coordinator ☐ Friend ☐ Relative ☐ News Media-Newspaper ☐ Radio ☐ Television ☐ Facebook ☐ Ad-Digital ☐ Direct Mail ☐ Billboard

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

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
☐ Homeless living temporarily 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:

adapt
Integrated Health Care

FAMILY / HOUSEHOLD INCOME						
Check the amount closest to your monthly household income for the total number of people in your household:						
Number of People in Household	**1**	**2**	**3**	**4**	**5**	**6**
Household income is less than	☐ 1,568	☐ 2,129	☐ 2,689	☐ 3,250	☐ 3,810	☐ 4,370
Household income is less than	☐ 1,882	☐ 2,555	☐ 3,227	☐ 3,900	☐ 4,572	☐ 5,245
Household income is less than	☐ 2,196	☐ 2,980	☐ 3,765	☐ 4,550	☐ 5,334	☐ 6,119
Household income is less than	☐ 2,510	☐ 3,406	☐ 4,303	☐ 5,200	☐ 6,096	☐ 6,993
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).

adapt
Integrated Health Care

Today's Date: _____

MENTAL HEALTH SUPPLEMENTAL CLIENT REGISTRATION

CLIENT INFORMATION		
Client Full Legal Name:		
_____	_____	_____
First Name	**Middle Initial**	**Last Name**
Date of Birth:		

CLIENT HEALTH INFORMATION
Currently Pregnant: ☐ Yes ☐ No
Number of child dependents under 18 in household:
Current Tobacco Use: ☐ Never ☐ Former ☐ Current If Current, how much per day: **Type of Tobacco Use**: ☐ Cigarette ☐ Cigar ☐ Smokeless (chew) ☐ Vape ☐ Pipe **Have you tried to quit?** ☐ No ☐ Yes Quit method used (e.g., gum, patch): **Passive smoke exposure?** ☐ No ☐ Yes
Name of Patient's Primary Care Provider:

CLIENT LEGAL INFORMATION		
Client's Legal Information: ☐ Parole ☐ Probation ☐ Incarcerated ☐ Mental Health Court ☐ PSRB ☐ JPSRB ☐ Civil Commitment ☐ Other *(please specify):*		
Client's Number of Arrests in Past Month:	**Total Arrests:**	**Total DUII Arrests:**

_____ _____ _____

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)

adapt Integrated Health Care

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**?						

adapt
Integrated Health Care

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: ______________________

adapt
Integrated Health Care

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.

adapt
Integrated Health Care

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 relaying 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.

adapt
Integrated Health Care

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:_____

adapt
Integrated Health Care

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.

adapt
Integrated Health Care

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).

adapt
Integrated Health Care

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: ____________________