

# **MENTAL HEALTH**

## **ADULT NEW PATIENT PACKET**

*Packet Updated 02/01/26*

*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

*If you have a life threatening emergency,  
call 9-1-1 or go immediately to the nearest emergency room.*

| DOUGLAS COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                               |                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------|
| <div></div> <div>Primary Care &amp; Behavioral Medicine</div> <div>Ph: (541) 440-3500<div></div>621 W Madrone Street, Roseburg, OR 97470</div>                                                                                                                                                                                                                                                                                                                 | Mon–Thu, 7am–6pm   Fri, 7am–5pm<br>Closed Sat & Sun           | After Hours<br>Answering Service<br>(541) 440-3500                 |
| <div></div> <div>Primary Care &amp; Behavioral Medicine</div> <div>Ph: (541) 492-4550<div></div>671 SW Main Street, Winston, OR 97496</div>                                                                                                                                                                                                                                                                                                                    | Mon–Thu, 7am–6pm   Fri, 7am–5pm<br>Closed Sat & Sun           | After Hours<br>Answering Service<br>(541) 492-4550                 |
| <div></div> <div>Psychiatric Medical Services</div> <div>Ph: (541) 229-8973<div></div>621 W Madrone, Roseburg, OR 97470<div></div>680 Fir Street, Reedsport, OR 97467 (by appt only)</div>                                                                                                                                                                                    | Mon-Fri, 8am-5pm<br>Closed Sat & Sun                          | After Hours &<br>Weekends<br>24-Hour Crisis Line<br>(800) 866-9780 |
| <div></div> <div>Adult Mental Health Services</div> <div>Ph: (541) 440-3532<div></div>621 W Madrone Street, Roseburg, OR 97470<div></div>680 Fir Street, Reedsport, OR 97467 (by appt only)</div>                                                                                                                                                                             | Mon-Fri, 8am-5pm<br>Closed Sat & Sun                          |                                                                    |
| <div></div> <div>Adult Substance Use Treatment Services</div> <div>Ph: (541) 672-1761<div></div>621 W Madrone Street, Roseburg, OR 97470</div>                                                                                                                                                                                                                                                                                                                 | Mon-Fri, 8am-5pm<br>Closed Sat & Sun                          |                                                                    |
| <div></div> <div>Youth Mental Health Services</div> <div>Ph: (541) 229-8934<div></div>548 SE Jackson St., Roseburg, OR 97470</div>                                                                                                                                                                                                                                                                                                                             | Mon-Fri 8am-5pm<br>Closed Sat & Sun                           |                                                                    |
| <div></div> <div>Youth Substance Use Treatment Services</div> <div>Ph: (541) 492-0172<div></div>548 SE Jackson St., Roseburg, OR 97470</div>                                                                                                                                                                                                                                                                                                                | Mon-Fri 8am-5pm<br>Closed Sat & Sun                           |                                                                    |
| COOS COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                               |                                                                    |
| <div></div> <div>Primary Care &amp; Behavioral Medicine - Bandon</div> <div>Ph: (541) 347-2529<div></div>1010 1st St. SE Suite 110, Bandon, OR 97411</div>                                                                                                                                                                                                                                                                                                 | Mon-Thu, 7am-6pm<br>Fri, 7am-5pm                              | 24-Hour Crisis Line<br>(541) 266-6800                              |
| <div></div> <div>Pharmacy Services - Bandon</div> <div>Ph: (541) 347-2724<div></div>1010 1st St. SE Suite 110, Bandon, OR 97411</div>                                                                                                                                                                                                                                                                                                                      | Mon-Thu, 9am-6pm<br>Fri, 9am-5pm                              |                                                                    |
| <div></div> <div>Adult &amp; Youth Mental Health &amp; Substance Use Treatment Services</div> <div>Ph: (541) 751-0357<div></div>400 Virginia Ave., Suite 201, North Bend, OR 97459</div>                                                                                                                                                                                                                                                                   | Mon-Fri, 8am-5pm<br>Closed Sat & Sun                          |                                                                    |
| CURRY COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                               |                                                                    |
| <div></div> <div>Primary Care &amp; Behavioral Medicine – Port Orford</div> <div>Ph: (541) 366-5094<div></div>1312 Tichenor Ave. Port Orford, OR 97465</div>                                                                                                                                                                                                                                                                                               | Wed, 8am-4:30pm                                               | 24-Hour Crisis Line<br>(877) 519-9322                              |
| <div></div> <div>Pharmacy Services – Port Orford</div> <div>Ph: (541) 366-5094<div></div>1312 Tichenor Ave. Port Orford, OR 97465</div>                                                                                                                                                                                                                                                                                                                    | Mon-Fri, 9am-5pm                                              |                                                                    |
| <div></div> <div>Adult &amp; Youth Mental Health &amp; Substance Use Treatment Services</div> <div>(877) 408-8941<div></div>615 5th St., Brookings, OR 97415<div></div>29845 Airport Way, Gold Beach, OR 97444<div></div>1403 Oregon St., Port Orford, OR 97465 (by appt only)</div> | Mon-Fri, 8am-5pm<br>Closed 12-1 for Lunch<br>Closed Sat & Sun |                                                                    |
| JOSEPHINE COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                               |                                                                    |
| <div></div> <div>Adult &amp; Youth Mental Health &amp; Substance Use Treatment Services</div> <div>(541) 474-1033<div></div>356 NE Beacon Drive, Grants Pass, OR 97526</div>                                                                                                                                                                                                                                                                               | Mon-Fri 8am-5pm<br>Closed Wed 1pm-3pm<br>Closed Sat & Sun     | 24-Hour Crisis Line<br>(541) 474-5360                              |

## 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.*

**SLIDING FEE DISCOUNT PROGRAM**

Please keep this page for your records.

Please complete the next page and return it to Adapt by the due date shown above.

Adapt Integrated Health Care offers a Sliding Fee Discount Program to help lower the cost of care for patients who qualify. **All patients are encouraged to apply for a Sliding Fee Discount**, including patients with insurance. Eligibility is based on family size and combined household income. No one is turned away due to lack of funds.

- You must return the Sliding Fee Discount Application form within 14 days of your visit to get a discount for that visit. If you return it later, the discount will start on the date we receive it.
- Discounts cannot be applied to past visits.
- After we process your application, you will get a letter in the mail telling you what discount you qualify for.
- Discounts last for one year. At that time, you will need to provide updated proof of income. If your financial or living situation changes before then, you must tell Adapt. Your discount may change.
- 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, call the Adapt billing office to make payment arrangements.
- The information on this form may also be used to see if you qualify for a discount on CHI Mercy Health Outpatient Lab & Imaging services ordered by Adapt Primary Care. To get a discount from CHI Mercy Health, you must first apply for the Oregon Health Plan. CHI Mercy Health may request this information for review.

**Required Documents:** To apply for a Sliding Fee Discount, include copies of the required documents for everyone in your household. **If a document does not apply to your household, you can skip it.**

- |                                                                            |                                                                       |                                                                                                                                                                     |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Most recent 30 days of pay stubs                  | <input type="checkbox"/> Child Support 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"/> Workers' Compensation award letter           | <input type="checkbox"/> Food Stamps verification                                                                                                                   |
| <input type="checkbox"/> Most recent federal tax return (if self-employed) | <input type="checkbox"/> Court orders from any lawsuit                | <input type="checkbox"/> Tuition assistance grants                                                                                                                  |
| <input type="checkbox"/> Social Security and/or Disability award letters   | <input type="checkbox"/> Proof of gambling winnings                   |                                                                                                                                                                     |
| <input type="checkbox"/> Pension award letter                              | <input type="checkbox"/> Proof of annuity payments                    |                                                                                                                                                                     |
|                                                                            | <input type="checkbox"/> Receipts for goods sold or services provided |                                                                                                                                                                     |

**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.

**Do you want to apply for a Sliding Fee Discount?**
☐ **Yes, I want to apply**

If "Yes," please fill out the rest of this form as fully as you can and sign below.

☐ **No, I do not want to apply**

If "No," you can apply later at any time. Please sign and date here:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If you are applying for a Sliding Fee Discount, you may also qualify for the Oregon Health Plan (OHP). If you want to apply for OHP and would like free help, 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? \_\_\_\_\_

**PLEASE PROVIDE INFORMATION FOR THE PERSON RESPONSIBLE FOR THIS ACCOUNT BELOW.**

Name of Responsible Party:

Relation to Patient:

Social Security (optional last 4): XXX-XX-

Date of Birth:

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 ↓ | 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:                      | \$                                                                        | \$        | \$        | \$        | \$        | \$        |
| <b>TOTAL</b>                | <b>\$</b>                                                                 | <b>\$</b> | <b>\$</b> | <b>\$</b> | <b>\$</b> | <b>\$</b> |

**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.**
☐ **Patient declined to apply for a Sliding Fee Discount**

Information verified by: ☐ Pay Stubs ☐ Tax Return ☐ Other \_\_\_\_\_

Staff member completing form: \_\_\_\_\_ Date: \_\_\_\_\_

## ADULT PATIENT 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:                            |
| <b>Phone (please check your primary phone):</b><br><input type="checkbox"/> Home Phone: _____ <input type="checkbox"/> Cell Phone: _____<br><input type="checkbox"/> Message Phone: _____ <input type="checkbox"/> Email: _____                                                                                                                                                  |      |                             |                                                      |                                 |
| <b>Patient Occupation:</b> _____<br><b>Employer:</b> _____ <b>Employer Phone:</b> _____                                                                                                                                                                                                                                                                                          |      |                             |                                                      |                                 |
| <b>Employment Status (check one):</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal/Temporary <input type="checkbox"/> Self-Employed<br><input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled                                |      |                             |                                                      |                                 |
| <b>Student Status:</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not a Student                                                                                                                                                                                                                                              |      |                             | <b>Highest School Grade Patient Completed:</b> _____ |                                 |
| <b>Patient's Legal Guardian or Representative:</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> ).<br><b>Legal Guardian or Representative Name:</b> _____ <b>Date of Birth:</b> _____<br><b>Social Security #:</b> _____ <b>Phone:</b> _____ |      |                             |                                                      |                                 |
| INSURANCE INFORMATION (Provide copies of your insurance cards)                                                                                                                                                                                                                                                                                                                   |      |                             |                                                      |                                 |
| <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 (if applicable):</b>                                                                                                                                                                                                                                                                                                                              |      |                             |                                                      |                                 |
| Group #:                                                                                                                                                                                                                                                                                                                                                                         |      | Policy #:                   |                                                      |                                 |
| Policyholder (PH) Name:                                                                                                                                                                                                                                                                                                                                                          |      | PH Date of Birth:           |                                                      |                                 |
| PH Social Security #:                                                                                                                                                                                                                                                                                                                                                            |      | PH Relationship to Patient: |                                                      |                                 |



**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):

**Sliding Fee Discount:** Were you offered or did you receive a Sliding Fee Discount application (also called Financial Discount Application)?

☐ Yes

☐ No

**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**

**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>                       |
|----------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| Monthly Household Income is less than                                                              | <input type="checkbox"/> 1,662 | <input type="checkbox"/> 2,254 | <input type="checkbox"/> 2,845 | <input type="checkbox"/> 3,437 | <input type="checkbox"/> 4,029 | <input type="checkbox"/> 4,620 |
| Monthly Household Income is less than                                                              | <input type="checkbox"/> 1,995 | <input type="checkbox"/> 2,705 | <input type="checkbox"/> 3,415 | <input type="checkbox"/> 4,125 | <input type="checkbox"/> 4,835 | <input type="checkbox"/> 5,545 |
| Monthly Household Income is less than                                                              | <input type="checkbox"/> 2,327 | <input type="checkbox"/> 3,155 | <input type="checkbox"/> 3,984 | <input type="checkbox"/> 4,812 | <input type="checkbox"/> 5,640 | <input type="checkbox"/> 6,469 |
| Monthly Household Income is less than                                                              | <input type="checkbox"/> 2,660 | <input type="checkbox"/> 3,606 | <input type="checkbox"/> 4,553 | <input type="checkbox"/> 5,500 | <input type="checkbox"/> 6,446 | <input type="checkbox"/> 7,393 |
| Monthly 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).

**FOR OFFICE USE ONLY**

**Date Packet Received:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Received By (Staff Initials):** \_\_\_\_\_

**Date Patient Record Updated:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Completed By (Staff Signature):** \_\_\_\_\_

Today's Date: \_\_\_\_\_

## MENTAL HEALTH SUPPLEMENTAL CLIENT REGISTRATION

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

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

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Race and Ethnicity

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

\_\_\_\_\_

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

### Hispanic and Latino/a/x

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

### Native Hawaiian and Pacific Islander

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

### White

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

### American Indian and Alaska Native

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

### Black and African American

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

### Middle Eastern/North African

- ☐ Middle Eastern
- ☐ North African

### Asian

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

### Other categories

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

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

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

**Language** (*Interpreters are available at no charge*)4a. What language or languages do you **use** at home? \_\_\_\_\_**Skip to question 7 if you indicated English only**4b. In what language do you want us to communicate in **person, on the phone, or virtually** with you?  
\_\_\_\_\_4c. In what language do you want us to **write** to you? \_\_\_\_\_5a. Do you need or want an **interpreter** for us to communicate with you?☐ Yes   ☐ No   ☐ Don't know   ☐ Don't want to answer

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

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

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

6. How well do you speak English?

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

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

Yes

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

No

Don't know

Don't want to answer

Don't know what this question is asking

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

## CONDITIONS FOR TREATMENT

### **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**

#### 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:** \_\_\_\_\_

## APPOINTMENT & PICK-UP AUTHORIZATION

\_\_\_\_\_

**Legal Last Name**

\_\_\_\_\_

**First Name**

\_\_\_\_\_

**MI**

\_\_\_\_\_

**Date of Birth**

The people you list on this form can help you make or cancel appointments. They can also pick up papers, prescriptions, and other information for you. However, we are not allowed to talk with them about your medical or mental health information. If you want us to share your health information with someone else, you'll need to fill out another form called a Release of Information (ROI).

|                                                                                                                                                                                                                                                                                                                        |                     |                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------|
| _____                                                                                                                                                                                                                                                                                                                  | _____               | _____               |
| <b>Contact Name</b>                                                                                                                                                                                                                                                                                                    | <b>Relationship</b> | <b>Phone Number</b> |
| <b>(check all that apply)</b><br><input type="checkbox"/> Appointment management<br><input type="checkbox"/> Pick up items from clinic, such as medications, hard copy prescriptions, and correspondence<br><input type="checkbox"/> This is a person Adapt may contact if I have a medical emergency during my visit. |                     |                     |

|                                                                                                                                                                                                                                                                                                                        |                     |                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------|
| _____                                                                                                                                                                                                                                                                                                                  | _____               | _____               |
| <b>Contact Name</b>                                                                                                                                                                                                                                                                                                    | <b>Relationship</b> | <b>Phone Number</b> |
| <b>(check all that apply)</b><br><input type="checkbox"/> Appointment management<br><input type="checkbox"/> Pick up items from clinic, such as medications, hard copy prescriptions, and correspondence<br><input type="checkbox"/> This is a person Adapt may contact if I have a medical emergency during my visit. |                     |                     |

|                                                                                                                                                                                                                                                                                                                        |                     |                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------|
| _____                                                                                                                                                                                                                                                                                                                  | _____               | _____               |
| <b>Contact Name</b>                                                                                                                                                                                                                                                                                                    | <b>Relationship</b> | <b>Phone Number</b> |
| <b>(check all that apply)</b><br><input type="checkbox"/> Appointment management<br><input type="checkbox"/> Pick up items from clinic, such as medications, hard copy prescriptions, and correspondence<br><input type="checkbox"/> This is a person Adapt may contact if I have a medical emergency during my visit. |                     |                     |

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**

\_\_\_\_\_

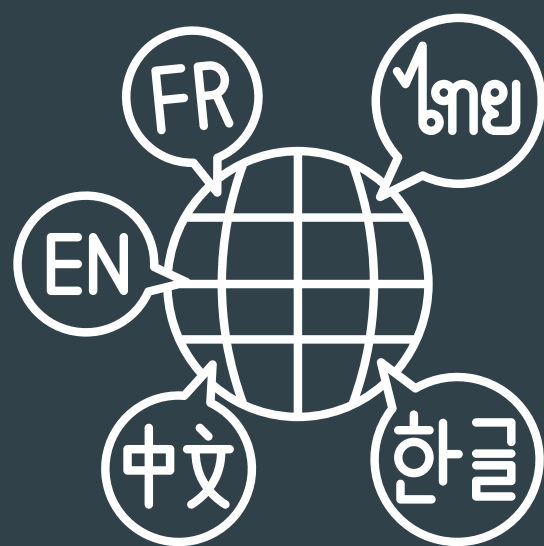
**Date**

\_\_\_\_\_

**Parent or Legal Guardian Signature**

\_\_\_\_\_

**Relationship to Patient**



## American Sign Language

Point to your language. An interpreter will be called. There is no cost to you. It is your right.



## Chinese

中文

请指出您的语言。我们将为您安排一位口译员。您无需支付任何费用。这是您的权利。

## Spanish

Español

Señale su idioma. Se llamará a un intérprete. No tendrá ningún costo para usted. Es su derecho

## French

le français

Indiquez votre langue. Un interprète sera appelé. Cela ne vous coutera rien. C'est votre droit

## Korean

한국어

당신의 언어를 가리켜 주세요. 통역사가 호출될 것입니다. 비용은 들지 않습니다. 이것은 당신의 권리입니다

## Japanese

日本語

「ご自身の言語を指さしてください。通訳が呼ばれます。費用はかかりません。これはあなたの権利です。」

## German

Deutsch

Zeigen Sie auf Ihre Sprache. Eine Dolmetscherin wird gerufen. Es entstehen Ihnen keine Kosten. Es ist Ihr Recht

## Mon-Khmer, Cambodian

ខ្មែរ

សូមចង្អុលទៅភាសារបស់អ្នក។ នរណាម្នាក់នឹងត្រូវបានហៅមកបកប្រែ។ អ្នកមិនត្រូវបង់ថ្លៃអ្វីឡើយ។ នេះជាសិទ្ធិរបស់អ្នក។

## Persian

فارسی

به زبان خود اشاره کنید. یک مترجم فراخوانده خواهد شد. این برای شما هیچ هزینه‌ای ندارد. این حق شماست

## Romanian

română

Arătați spre limba dumneavoastră. Va fi chemat un interpret. Nu veți avea niciun cost. Este dreptul dumneavoastră

## Russian

Русский язык

Укажите на свой язык. Будет вызван переводчик. Это бесплатно для вас. Это ваше право

## Cushite

Kushiya

Farta ku fiiq luqaddaada. Turjubaan ayaa laguugu yeeri doonaa. Kharash kugu ma baxayo. Waa xuquuqdaada

## Thai

ภาษาไทย

ชี้ไปที่ภาษาของคุณ จะมีการเรียกหาล่าม คุณไม่ต้องเสียค่าใช้จ่ายใด ๆ นี่คือนิติของคุณ

## Ukrainian

українська мова

Вкажіть на свою мову. Буде викликано перекладача. Це безкоштовно для вас. Це ваше право

## Vietnamese

Tiếng Việt

Chỉ vào ngôn ngữ của bạn. Một thông dịch viên sẽ được gọi. Bạn sẽ không phải trả bất kỳ chi phí nào. Đây là quyền của bạn

## Arabic

العربية

أشر إلى لغتك. سيتم استدعاء مترجم. لن تتحمل أي تكلفة. هذا من حقك



Point to your language.  
An interpreter will be called.