ACKNOWLEDGMENT AND CONSENT FOR TREATMENT

I am voluntarily applying for services at the Deschutes County Health Services (DCHS). I understand and agree that Deschutes County Health Services (DCHS) may use and disclose my health information in order to:

• Make decisions about and plan for my care and treatment;
• Refer to, consult with, coordinate among, and manage along with other health care providers, including other providers within DCHS, for my care and treatment;
• Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
• Perform various office, administrative, and business functions that support DCHS efforts to provide me with, and be reimbursed for, quality cost-effective health care; and
• Participate as a member of the OCHIN Collaborative, as described in the Notice of Privacy Practices for Deschutes County Health Services.
• Participate as a member of the Reliance Community Health Information Exchange, as described in the Notice of Privacy Practices for Deschutes County Health Services.

I understand that my health information may include information both created and received by DCHS, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand that the health information used or disclosed may include vocational rehabilitation, alcohol and drug records, HIV/AIDS records, genetics information, and mental health or developmental disability records held by publicly funded providers.

I understand that the Notice of Privacy Practices for Deschutes County Health Services may be revised from time to time and that I am entitled to receive a copy of any revised version. I also understand that a copy or a summary of the most current version of the Notice of Privacy Practices for Deschutes County Health Services in effect will be posted in the waiting / reception areas.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices for Deschutes County Health Services, and I understand that DCHS is not required by law to agree to such requests.

By signing below, I agree that I am requesting services from DCHS, have reviewed the information above and that I have received a copy of the Notice of Privacy Practices for Deschutes County Health Services.

Printed Client’s Name: ________________________________

By: _____________________________________________ Date: ________________

Patient or Patient’s Authorized Personal Representative

By: _____________________________________________ Date: ________________

DCHS Employee Witness Signature

Revised 8/2/2018
**PATIENT INFORMATION**

**PLEASE PRINT:** (Information about the individual seeking services)  

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>DOB</th>
<th>Full Name at Birth</th>
<th>SSN</th>
</tr>
</thead>
</table>

What is your identified gender  
- [ ] Female  
- [ ] Male  
- [ ] Female-to-male (FTM)/Transgender Male/Trans Man  
- [ ] Male-to-Female (MTF)/Transgender Female/Trans Woman  
- [ ] Gender non binary, neither exclusively male nor female  
- [ ] Additional gender category/ (or Other), please specify: __________________________________________

What sex were you assigned at birth on your original birth certificate?  
- [ ] Male  
- [ ] Female  
- [ ] Decline to answer  

Preferred Pronoun (She, He, They, Other)  

Preferred Name: ____________________________

Home #  

For confidential consideration, where may we leave a message (mark all that apply)  
- [ ] Home  
- [ ] Cell  
- [ ] Work  
- [ ] Message #

Cell #

Work/Message #

Street/Physical Address  

City  

State  

Zip

Mailing/Secondary Address (if different)  

City  

State  

Zip

County of Residence  

Individual resides with  
- [ ] Living Alone

Reason For Seeking Services

**INDIVIDUAL NEEDS**

Interpreter/Special Needs (Please mark all that apply):  
- [ ] Hearing Impaired/Aid  
- [ ] Reading/Literacy Aid  
- [ ] None  
- [ ] Other________________

Preferred Language Interpreted: If so, what Language: ____________________________

---

Deschutes County encourages persons with disabilities to participate in all programs and activities. This location is accessible to people with disabilities. If you need accomodations to make participation possible, please call 541-322-7500.
**EMERGENCY CONTACT**

First and Last Name of Emergency Contact:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

*Emergency Information*

Can we leave a message (Please choose)  
☐ Yes  ☐ No  

Phone #

**MILITARY STATUS**

Have you ever served in the military?  
☐ Yes  ☐ No

Are you currently serving (reserve/active)?  
☐ Yes  ☐ No

**MARITAL STATUS**

☐ Married  ☐ Divorced  ☐ Domestic Partnership
☐ Significant Other  ☐ Domestic Partnership  ☐ Widowed  ☐ Other
☐ Single  ☐ Domestic Partnership  ☐ Other
☐ Legally Separated

Name of spouse/partner (if applicable):

**LIVING ARRANGEMENT**

Please choose which best describes your living situation

☐ Homeless  ☐ Foster Home  ☐ Residential Facility/Group Home
☐ Jail  ☐ Prison  ☐ Room and Board
☐ Supportive Housing  ☐ Supportive Housing (scattered site)  ☐ Supportive Housing (Congregate Setting)
☐ Alcohol/Drug Free Housing  ☐ Oxford Home  ☐ Other Private Residence
☐ Private Residence (Home)  ☐ Private Residence (relative)  ☐ Private Residence (non-relative)
☐ Residential Facility (SUD)  ☐ Residential Facility (BRS)  ☐ Residential Facility (CSEC)
☐ Residential Facility (PRTS)  ☐ Residential Facility (SCIP/SAIP)  ☐ Residential Facility (SRTF for YAT)
☐ Unknown
### RACE AND ETHNICITY

Race (Please mark all that apply)
- [ ] Alaska Native
- [ ] Black/African American
- [ ] Hispanic
- [ ] Asian
- [ ] Hawaiian/Pacific Island
- [ ] American Indian
- [ ] White/Caucasian
- [ ] Other
  - [ ] Single race
  - [ ] Two or more races

Tribal Affiliations (Please mark all that apply)
- [ ] Burns Paiute Tribe
- [ ] Confederated Tribes of Grand Ronde
- [ ] Confederated Tribes of the Umatilla
- [ ] Coquille Indian Tribe
- [ ] Klamath Tribes
- [ ] Other (Please describe):

### LEGAL STATUS

Please choose which best describes your situation
- [ ] DUII Diversion Client
- [ ] 90 Day Civil Commitment
- [ ] Parole
- [ ] Juvenile PSRB
- [ ] Aid and Assist
- [ ] Unknown
- [ ] DUII Convicted Client
- [ ] 180 day Civil Commitment
- [ ] Probation
- [ ] Guardianship (Child Welfare)
- [ ] None
- [ ] 30 Day Civil Commitment
- [ ] Incarcerated
- [ ] Psychiatric Services Review Board (PSRB)
- [ ] Guardianship (Court)
- [ ] Involuntary Custody

### EDUCATION

Check highest grade individual completed
- [ ] K
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10
- [ ] 11
- [ ] 12/GED
- [ ] AA/AS
- [ ] BA/BS
- [ ] MA/MS
- [ ] PHD/PSYD/MD
- [ ] College Courses Taken

### OTHER INFORMATION

Have you had previous mental health counseling?
- [ ] Yes
- [ ] No
If Yes, Where?

Referred by

Is there Child Protective Services involvement?
- [ ] Yes
- [ ] No

Caseworker Name

Phone #

Do you have a Declaration for Mental Health Treatment and/or an Advanced Directive?
- [ ] Yes
- [ ] No

Would you like help completing a Declaration for Mental Health Treatment?
- [ ] Yes
- [ ] No
FINANCIAL INFORMATION

**HEALTH INSURANCE**

<table>
<thead>
<tr>
<th>Name of Individual Seeking Services</th>
<th>Name of Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Insurance Plan ID #*(OHP, Medicare, etc.)</td>
<td>Policy Holder Name and DOB* (Required if not self)</td>
</tr>
<tr>
<td>Secondary Health Insurance Plan ID #</td>
<td>Policy Holder Name and DOB*(Required if not self)</td>
</tr>
</tbody>
</table>

**EMPLOYMENT STATUS**

Please choose the one that best describes your employment status

- [ ] Full Time
- [ ] Part Time
- [ ] Unemployed
- [ ] Student
- [ ] Disabled
- [ ] Homemaker
- [ ] Retired
- [ ] Not in Labor Force
- [ ] Other (volunteer etc.)
- [ ] Hospital Patient, Incarcerated or Other Residential Institution
- [ ] Unknown
- [ ] Sheltered Employment (Opportunity Foundation, Good Will, etc.)

**INCOME**

<table>
<thead>
<tr>
<th>Monthly household income sources</th>
<th>Self</th>
<th>Spouse</th>
<th>Parent(s)</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages (salaries, tips, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement/Pension/SSI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability/SSDI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

None: If no income to report. Explain how you are supported:

---

Deschutes County encourages persons with disabilities to participate in all programs and activities. This location is accessible to people with disabilities. If you need accommodations to make participation possible, please call 541-322-7500.

Revised 8/2/2018

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FINANCIAL INFORMATION

<table>
<thead>
<tr>
<th>HOUSEHOLD MEMBERS AND DEPENDENTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>List number of household members living with you in each category</td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>Spouse/Partner</td>
</tr>
</tbody>
</table>

- I confirm that the information shown is correct and I know proof is required for approval. Despite my insurance status or ability to provide proof, I am responsible for the balance on my account for any professional services delivered by DCBH. I approve the release of any medical and financial facts necessary to process insurance claims.

- I will notify DCBH promptly of any change to the above information.

**Responsible Party Signature**

Date

Please do not write in shaded boxes (Staff use only)

<table>
<thead>
<tr>
<th>STAFF VERIFICATION CHECKLIST (attach copies)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Proof of ID: Photo ID, Drivers License, Birth Certificate, Social Security Card</td>
<td>Sliding Fee amount:</td>
</tr>
<tr>
<td>Effective Date</td>
<td></td>
</tr>
<tr>
<td>Staff Signature Line-please sign after explaining financial and sliding fee scale to responsible party</td>
<td>Date of staff signature</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
<tr>
<td>Responsible Party Initials</td>
<td>Expiration date</td>
</tr>
</tbody>
</table>
**DESCHUTES COUNTY HEALTH SERVICES**  
**MEDICAL HISTORY FORM**

Confidential Medical Information

- Individuals 14+ please complete. Parents or caregivers need to complete the form for children age 13 and under. The following information is needed to help understand your mental and physical health conditions. It is not required that you answer all of these questions to participate in an assessment or treatment. However, we would appreciate it if you would take the time to fill out as much of this form as possible.

**INDIVIDUAL NAME:** ___________________________  
**DATE:** ___________________________

<table>
<thead>
<tr>
<th>MEDICAL HISTORY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Major accidents</td>
<td>☐ Diabetes</td>
</tr>
<tr>
<td>☐ Drug overdose</td>
<td>☐ Asthma or breathing problem</td>
</tr>
<tr>
<td>☐ Kidney problems</td>
<td>☐ Neurological problems</td>
</tr>
<tr>
<td>☐ Skin infections</td>
<td>☐ Sexually transmitted infection</td>
</tr>
<tr>
<td>☐ High blood pressure</td>
<td>☐ Liver problems</td>
</tr>
<tr>
<td>☐ Mental Health Hospitalization</td>
<td>☐ Suicidal thoughts</td>
</tr>
<tr>
<td>☐ Rash</td>
<td>☐ Cardiac disease</td>
</tr>
<tr>
<td>☐ Hallucinations</td>
<td>☐ Hepatitis (A,B or C)</td>
</tr>
<tr>
<td>☐ Severe drug/alcohol withdrawal</td>
<td>☐ Head injury</td>
</tr>
<tr>
<td>☐ Physical/Emotional/Intellectual/Developmental Disability</td>
<td></td>
</tr>
</tbody>
</table>

Allergies to medications (Please list)

Other issues not listed above (Please list)

**Explain any of the checked above that you have experienced within the last 6 months**

Approximate dates for major accidents/injuries, illnesses and mental health hospitalizations

**Do you currently have a doctor** ☐ Yes ☐ No  
If yes, name of Doctor  
Last date you saw your doctor

**Are you currently taking any medication** ☐ Yes ☐ No  
If yes, please list medications and dosages

**Nicotine/Tobacco use** ☐ Yes ☐ No  
Amount per day

**Are you interested in cutting back/ quitting** ☐ Yes ☐ No  
Would you like a Tobacco Quit Line referral ☐ Yes ☐ No

**Any substance/drug use during the last 90 days** ☐ Yes ☐ No ☐ Unknown

**Are you pregnant** ☐ Yes ☐ No ☐ N/A  
If yes, due date
Infectious Disease Risk Assessment (IDRA) (ADULTS ONLY)

The following information is needed to help estimate your risk for HIV/AIDS and/or other infectious diseases. **It is not required that you answer these questions to participate in an assessment or counseling.** However, we would appreciate you taking the time to fill out as much of this as possible. **Your answers to these questions will be kept confidential.** Your signature at the end of this page indicates that you have read and/or answered this information.

**Tuberculosis (TB)**

- Have you ever been diagnosed or treated for TB? [ ] Yes [ ] No [ ] Don’t Know
- Have you known or lived with someone who was diagnosed with TB? [ ] Yes [ ] No [ ] Don’t Know
- Have you ever been homeless or lived in a shelter? [ ] Yes [ ] No
- Have you ever been in jail/prison? [ ] Yes [ ] No

*If you answered “Yes” to any of the above TB questions, please proceed to TB Symptoms questions. If you answered “No” to all TB questions proceed to STDs section.*

**TB Symptoms**

- Do you have a fever? [ ] Yes [ ] No
- Do you sweat excessively at night (unrelated to room temperature)? [ ] Yes [ ] No
- Do you have a cough that has lasted for many weeks? [ ] Yes [ ] No
- Do you cough up blood? [ ] Yes [ ] No
- Do you get shortness of breath? [ ] Yes [ ] No
- Have you lost weight without meaning to? [ ] Yes [ ] No

*If you answered “Yes” to two or more symptoms, please call the disease reporting line at 322-7418 for immediate follow-up. If you answered “No” to all symptoms, you may contact 322-7400 for a voluntary screening appointment.*

**STDs**

- Have you or anyone you have had sex with had any sexually transmitted diseases? [ ] Myself [ ] Partner [ ] No [ ] Don’t Know

**Hepatitis, HIV/AIDS**

Many people are worried about Hepatitis C and HIV/AIDS. Some should be worried and need to make changes to avoid being infected or spreading the infection to others. However, many people are not at risk of Hepatitis C or HIV (the virus known to cause AIDS). To find out if you are at an increased risk, please consider the following questions.

- Have you used needles to inject drugs? [ ] Yes [ ] No
- In the past 12 months have you had a tattoo, ear/body piercing, or acupuncture from an unauthorized facility or come into contact with someone else’s blood? [ ] Yes [ ] No

Have you had **unprotected** sex with:

- a person who has injected illicit drugs [ ] Yes [ ] No [ ] Don’t Know
- more than one person in the past 6 months? [ ] Yes [ ] No [ ] Don’t Know
- a person in exchange for money, drugs, or in order to survive? [ ] Yes [ ] No [ ] Don’t Know
- a man who has had sex with another man? [ ] Yes [ ] No [ ] Don’t Know
- someone who has the blood disease hemophilia? [ ] Yes [ ] No [ ] Don’t Know

*If you answered “Yes” or “Don’t Know” to any of the previous questions, you may be at increased risk for Hepatitis B, Hepatitis C, HIV, TB, or other infectious diseases. You may want to contact the Public Health Division or your primary care physician for an appointment to have a current HIV, TB, or STD test.*

---

Individual or Caregiver Signature
**AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION**

<table>
<thead>
<tr>
<th>Legal Last Name of Client:</th>
<th>First:</th>
<th>MI:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other names used by Client:

By signing this form, I authorize the following record holder to disclose the following specific confidential information.

<table>
<thead>
<tr>
<th>Record Holder’s Identity:</th>
<th>Specific information to be disclosed: (include date range if applicable):</th>
<th>*Mutual Exchange: Please Initial and Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deschutes County Behavioral Health</td>
<td></td>
<td>YES or NO</td>
</tr>
</tbody>
</table>

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information: Please Initial under either authorize or refuse. *Mutual exchange allows information to be released back and forth between the record holder(s) and the recipient(s).

<table>
<thead>
<tr>
<th>Authorize or Refuse:</th>
<th>Authorize or Refuse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______ or _______ HIV/AIDS</td>
<td>_______ or _______ Alcohol/Drug diagnosis, treatment, referral</td>
</tr>
<tr>
<td>_______ or _______ Genetic Testing Information</td>
<td>_______ or _______ Mental Health (except psychotherapy notes)</td>
</tr>
</tbody>
</table>

**RECIPIENT**

Release to: (address required if information is to be mailed to recipient). If releasing to a team, list members.

**Primary Care Provider** List below:

Purpose of release: 

Expiration date or event:**

**ACKNOWLEDGEMENT**

**This authorization is valid for one year from the date of signing unless otherwise specified.**

I understand that I can cancel this authorization at any time by providing written notice of cancellation to the above-identified record holder(s). Such cancellation will not affect any information that was already disclosed. I understand I may refuse to sign this form. I know that, except when services are provided for research purposes or solely for the purpose of creating protected health information for disclosure to a third person, Deschutes County cannot deny Client services if I do not sign this authorization.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected under federal or state law, EXCEPT THAT re-disclosure by the recipient of information related to HIV/AIDS, mental health, alcohol or drug treatment, or genetic testing information is prohibited without my authorization unless otherwise permitted by federal or state law.

I understand that Client’s personal health information is confidential and may be protected by state and federal laws, and I approve the release of Client’s personal health information in accordance with this authorization. I am signing this authorization voluntarily and without pressure or coercion. I acknowledge that I have been offered a copy of this form. I acknowledge that I have reviewed Deschutes County’s written “Notice of Privacy Practices For Deschutes County.”

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>Relationship to Client:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Print Name of Person Signing This Authorization X

Revised 8/2/2018
Information Packet Receipt Acknowledgement

By initialing and signing this form, you acknowledge receipt or declination of the following information from Deschutes County Health Services, Behavioral Health. We encourage you to review all forms in the Client Information Packet carefully. You may obtain copies by visiting our website or on request from our staff.

The Client Information Packet contains the following information:

- Individual Rights and Responsibilities
- Notice of Privacy Practices
- Information concerning grievances and appeals (including a grievance form)
- Copy of the Acknowledgment and Consent for Treatment
- Voter Registration information, as requested
- Declaration of Mental Health Treatment information, as requested

Please initial next to whether you received or declined the Client Information Packet:

_____ I accepted the Client Information Packet

☐ I requested and received voter registration information

☐ I requested and received Declaration of Mental Health Treatment information

_____ I declined the Client Information Packet, additional information, or assistance

________________________________________   __________________________
Individual or Caregiver Signature               Date