DESCHUTES COUNTY HEALTH SERVICES

MRN # _____

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 ofmy 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 in the following as described in the Notice of Privacy Practices for Deschutes County Health Services;
    - Communicate with me through MyChart, an online secure patient portal.
    - As a member of the Reliance Community Health Information Exchange
    - Deschutes County Health Services is a member of an electronic health information exchange (HIE) called the OCHIN Collaborative. A purpose of this HIE is to allow health care providers to electronically share records regarding an individual. I understand and agree that DCHS may disclose any of my health information, including drug and alcohol treatment information protected by 42 CFR Part 2, to this HIE for the purpose of sharing the information with any individual or entity that has a treating provider relationship with me at the time he/she/it accesses the information. I understand that upon my written request, the HIE must provide me with a list of all entities to which my information has been disclosed within the past two years. The HIE would be responsible for responding to the request within 30 days.

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 been offered a copy of the Notice of Privacy Practices for Deschutes County Health Services.

Print Client's Name: _____ **Date:** _____

Signature (client, guardian, or authorized personal representative): _____

Print Name if signed by someone other than client: _____

Client Initials:_____ MRN # _____

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

DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

ADULT APPLICATION

MRN _____

PATIENT INFORMATION

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

Last Name	First Name	Middle Initial	DOB

Full Name at Birth	SSN

What is your identified gender?

☐ Female
☐ Male
☐ Two Spirit
☐ Gender non binary, neither exclusively male nor female
☐ Female-to-male (FTM)/Transgender Male/Trans Man
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Questioning
☐ Additional gender category/ (or Other), please specify: _____

What sex were you assigned at birth on your original birth certificate? ☐ Male ☐ Female ☐Intersex ☐ Decline to answer	Pronouns (She, He, They, Other): Preferred Name:

Contact information:

Privacy laws allow us to communicate with you using your preferred method, when reasonable. By completing this section, you are notifying DCHS of how you would like us to communicate with you, which can include information about your services. By selecting the methods listed below, you are agreeing to and accepting any liability involved.

Cell Phone:	OK to text: ☐Yes ☐No OK to leave detailed voicemail: ☐Yes ☐No
Home Phone:	OK to leave detailed voicemail: ☐Yes ☐No
Work Phone:	OK to leave detailed voicemail: ☐Yes ☐No
Email Address:	OK to send non-secure emails: ☐Yes ☐No

Street/Physical Address	City	State VI	Zip
Mailing/Secondary Address (if different)	City	State	Zip

County of Residence	Individual resides with: ☐ Living Alone Last: First: Relationship:

Reason For Seeking Services:

INDIVIDUAL NEEDS

Interpreter/Special Needs (Please mark all that apply):

☐ Hearing Impaired/Aid ☐ Reading/Literacy Aid ☐ None ☐Other_____

☐ Preferred language if other than English, please indicate: _____

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.

DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

Client Initials:_____ MRN _____

EMERGENCY CONTACT				
First and Last Name of Emergency Contact:				
Relationship	Address	City	State	Zip
*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 ☐ Significant Other ☐ Single ☐ Legally Separated	☐ Divorced ☐ Domestic Partnership ☐ Widowed ☐ Other	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	☐ Secure Residential (SRTF Adult)	☐ Residential Sub-Acute Care Facility
☐ Residential Facility (RTH for YAT)		

DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

Client Initials:_____ MRN _____

RACE AND ETHNICITY			
Race/Ethnicity (Please mark all that apply)			
☐ Alaska Native	☐ Black/African American	☐Mexican	☐Asian Indian
☐ Japanese	☐ Chinese	☐ Korean	☐ Other Asian
☐ Filipino	☐ Samoan	☐ Vietnamese	☐Guamanian or Chamorro
☐ Native Hawaiian	☐ White/Caucasian	☐ Other	☐ Other Pacific Islander
☐ Mexican American	☐ Cuban	☐ Puerto Rican	☐ Non-Hispanic or Latino/a
☐ Chicano/a	☐ Two or more races	☐ Single race	☐ Unknown
☐ Patient Refused	☐ Other Hispanic Latino/a or Spanish origin		
Tribal Affiliations (Please mark all that apply)			
☐ Burns Paiute Tribe		☐ Confederated Tribes of Coos, Lower Umpqua & Siuslaw	
☐ Confederated Tribes of Grand Ronde		☐ Confederated Tribes of Siletz	
☐ Confederated Tribes of the Umatilla		☐ Confederated Tribes of Warm Springs	
☐ Coquille Indian Tribe		☐ Cow Creek Band of Umpqua Indians	
☐ Klamath Tribes		☐ Not Applicable	
☐ Other (Please describe):			

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

EDUCATION
Check highest grade <u>individual</u> 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

MRN _____

FINANCIAL INFORMATION

HEALTH INSURANCE	
Name of Individual Seeking Services	Name of Responsible Party
Primary Health Insurance Plan ID #*(OHP, Medicare, etc.)	Policy Holder Name and DOB* (Required if not self)
Secondary Health Insurance Plan ID #	Policy Holder Name and DOB*(Required if not self)

EMPLOYMENT STATUS		
Please choose the one that best describes your employment status:		
☐ Full Time	☐ Disabled	☐ Retired
☐ Part Time	☐ Homemaker	☐ Not in Labor Force
☐ Unemployed	☐ Student	☐ Other (volunteer etc.)
☐ Hospital Patient, Incarcerated or Other Residential Institution		☐ Unknown
☐ Sheltered Employment (Opportunity Foundation, Good Will, etc.)		
Do you want help with employment? ☐Yes or ☐ No		

INCOME					
Monthly household income sources	Self	Spouse	Parent(s)	Other	Total
Wages (salaries, tips, etc.)					
Public Assistance					
Retirement/Pension/SSI					
Disability/SSDI					
Other					
None: If no income to report. Explain how you are supported:					

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DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

ADULT APPLICATION

MRN _____

FINANCIAL INFORMATION

HOUSEHOLD MEMBERS AND DEPENDENTS			
List number of household members living with you in each category			
Self	Spouse/Partner	Parent/Guardian	Dependents

- ❖ 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**)

STAFF VERIFICATION CHECKLIST (attach copies)		
Proof of ID: Photo ID, Drivers License, Birth Certificate, Social Security Card		Sliding Fee amount: Effective Date:
Staff Signature Line-please sign after explaining financial and sliding fee scale to responsible party Signature:		Date of staff signature
By initialing, I (responsible party) am stating that the financial & sliding fee scale process was explained to me if I were to lose OHP/Medicaid/Medicare/Private Insurance.	Responsible Party Initials	Expiration date

DESCHUTES COUNTY HEALTH SERVICES

MEDICAL HISTORY FORM

MRN:_____

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:**_____

MEDICAL HISTORY		
Please check the box if you have had or currently have any of the following:		
☐ Major accidents	☐ Diabetes	☐ Eating disorder
☐ Drug overdose	☐ Asthma or breathing problem	☐ GI bleeding
☐ Kidney problems	☐ Neurological problems	☐ Ulcer
☐ Skin infections	☐ Sexually transmitted infection	☐ Heart murmur
☐ High blood pressure	☐ Liver problems	☐ Lung or Pulmonary disease
☐ Mental Health Hospitalization	☐ Suicidal thoughts	☐ Pancreatitis
☐ Rash	☐ Cardiac disease	☐ Tuberculosis
☐ Hallucinations	☐ Hepatitis (A,B or C)	☐ Thyroid problems
☐ Severe drug/ alcohol withdrawal	☐ Head injury	☐ Seizures or convulsions
☐ Physical/Emotional/Intellectual/Developmental Disability		
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

Client Initials:_____ MRN # _____

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
Have you ever had sex with (or shared needles with) a person who tested positive for HIV or has AIDS?	☐ 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