



Deschutes County Health Services

RIGHTS AND RESPONSIBILITIES

Our Mission: To promote and protect the health and safety of our community.

When you contact us about services we begin a two way relationship with you as the consumer and us as the treatment provider. We want this relationship to be productive. We want the best care for you or your family. We will work together toward the best possible result for you and your situation.

We also know you will expect things from us. We expect certain things of you as well. Your “Rights” are the things that you can count on getting from us. Your “Responsibilities” are things we need from you. With everyone doing their part and trying their best to work together, we will promote and protect your health and safety and the health and safety of your family and our community.

YOUR RIGHTS

RESPECT

1. You will be treated with dignity and respect by DCBH staff;

ACCESS TO SERVICES

1. To give informed consent in writing prior to the start of services (except in a medical emergency or otherwise permitted by law);
2. To seek outpatient services on your own if you are age 14 or older, emancipated or under age 18 and legally married;
3. To seek services for a minor if you are the legal guardian;
4. Be treated in the same manner as any other individual seeking behavioral health services;
5. You do not need a referral from a doctor to get our services;
6. You will get care that is right for your condition;
7. You will get care that is approved for your condition;
8. You will get behavioral health services in a timely manner equal to access available to any other individual seeking the same services;
9. You will be notified in a timely way if we have to cancel your appointment;
10. You can get help or “Protected Services” if you are being abused;
11. You can get crisis care 24 hours a day, 7 days a week;
12. You have access to Peer Delivered Services

INFORMATION

1. You will be given information about your rights and responsibilities;
2. You will be given information about services;
3. You will be given information about behavioral health services covered or not covered by your health care plan;
4. You can choose the service options covered by your health care plan that works for you;
5. You can have services explained, including expected outcomes and possible risks;
6. You can have free written materials in a form you can understand;
7. You can have us explain written materials to you;
8. You can have a free interpreter if you are hearing impaired or if your primary language is not English.
9. You can have information about “The Declaration for Mental Health Treatment” and “Advance Directive” for health care decisions and what is involved in those processes;
10. You will get a written notice and hearing request information when your services are denied or changed;



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11. You will be informed before you receive a service not covered by your health care plan;
12. You will get information about fees before you receive a service;
13. You will receive prior notice of transfer, unless in circumstances necessitating transfer pose a threat to health and safety;

DIRECT YOUR CARE

1. We will give you our best effort to understand your condition;
2. We will give you details about your condition;
3. We will try our best to set up services that most closely meet your needs;
4. You can accept or decline services offered to you (except those required by court order);
5. We will inform you of how your decision to accept or not accept a service could affect your health;
6. We will not use the practice of “restraint” or “isolation” to punish you;
7. We will not “restrain” or “isolate” you to make you do something you don’t want to do;
8. You can get a second opinion about your diagnosis and treatment;
9. You may be referred to another provider if you need covered specialty care we do not provide;
10. You will be actively involved in making your plan for treatment;
11. You will be involved in making your child’s plan for treatment, if you are a parent or guardian;
12. You can have a friend, family member, or advocate with you at appointments;
13. You will be involved in decisions about your care;
14. You can change your provider or treatment agency, with a good reason;
15. You can choose whether or not you wish to take part in any new forms of treatment offered;

CONFIDENTIALITY

1. Your personal information will be kept private;
2. What you say to your provider will be kept confidential unless required by law;
3. You will have a record kept with information about your condition, services you received, and referrals that were made for you;
4. Your record will be kept private and confidential according to the law;
5. You can get a copy of your record unless it is restricted by law;
6. You can ask to change or correct the information in your record;
7. You can ask us to give information from your record to another provider;
8. No research information gathered will identify your personal information;
9. You can withdraw a release at any time;

EXERCISE YOUR RIGHTS

1. You have religious freedom, freedom from seclusion and restraint;
2. You will be given information about our complaint process;
3. You will not be punished in any way for making a complaint;
4. You will not be punished for exercising your rights;
5. You will not be discriminated against or restricted from services based on race, age, gender, ethnic or national origin, language spoken, disability, sexual orientation, political or religious beliefs, or marital status;
6. You can make a complaint about DCBH, and will get a timely answer;
7. You can record a “Complaint” or “Appeal”;
8. You can request a regular or speedy Department of Human Services Administrative Hearing;
9. You can ask for services to continue until a decision about an Appeal has been made;
10. You will be informed you may be responsible for paying for services that were continued if the Appeal decision is not in your favor.



Deschutes County Health Services

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YOUR RESPONSIBILITIES

RESPECT

1. Treat your provider and treatment agency staff with respect;

INVOLVEMENT

1. Be actively involved in creating your plan of care;
2. Ask questions about anything you don't understand;
3. Use information you have received to decide about your care before care is given;
4. Follow plans of care you have agreed to;
5. If three (3) scheduled appointments are missed (no show or late cancel) within a three-month period, or there is a pattern of missed appointments with no cancellation, your chart may be closed;

COMMUNICATION AND INFORMATION

1. Keep appointments with your provider;
2. Be on time for your appointments, If you arrive more than 15 minutes late your appointment may be cancelled;
3. Call ahead when you are going to be late or can't keep the appointment, we ask you call 24 hours ahead if possible;
4. Give your provider correct information about your behavioral health situation;
5. Give accurate information for your record;
6. Help your provider get previous behavioral health records;
7. Keep your address, phone number and insurance information up to date

HONORING GUIDELINES

1. Use services from your assigned provider except in an emergency;
2. Use urgent and emergency services appropriately;

PAYMENT

1. Show your insurance card to your treatment agency before you receive services.
2. Pay all fees when they are due;
3. Sign papers to confirm you have been informed of how much any services not covered by your insurance will cost, should you choose to use them;
4. Provide proof of income documents if requested;
5. Sign forms to verify you have been informed who is responsible for paying for services if you choose to get services that are not covered by your insurance.

You can get this document in a larger print size or in a different format. You can also get this document in some languages other than English. Contact the office listed below to ask for this.

Deschutes County Behavioral Health
2577 NE Courtney Drive
Bend, OR 97701

Phone: 541-322-7500
TTY: 541-322-7610
Fax: 541-322-7565

NOTICE OF PRIVACY PRACTICES FOR DESCHUTES COUNTY

What is protected?

- * Protected Health Information (PHI), which consists of any medical information containing your name or containing other publicly available information from which your identity can be determined.

Your PHI:

- * Is kept in written charts, or stored electronically (i.e., in a computer system.)
- * Includes records of evaluations, treatments, tests, visits, counseling sessions, and any other health care services you have received.

Protecting your privacy:

- * By law, we must keep your PHI confidential, except in certain situations.
- * We must give you a copy of this Notice.
- * All Deschutes County Employees and Volunteers must follow applicable privacy rules.
- * If there is a privacy breach that involves your PHI we will notify you.

IN MANY CASES, WE NEED YOUR WRITTEN AUTHORIZATION BEFORE WE CAN SHARE YOUR PHI WITH ANY PERSON.

However, we can share PHI without your written authorization in certain circumstances, such as:

- * Providing you with medical treatment or assisting another healthcare provider to treat you.
- * Running our organization.
- * Billing or obtaining payment for services.
- * Helping with public health and safety issues.
- * Conducting research.
- * As part of an organized healthcare arrangement (see "OCHIN," on next column).
- * As part of a community health information exchange (see "RELIANCE", on next column).
- * Complying with the law.
- * Responding to lawsuits and legal actions.
- * For law enforcement purposes.
- * Working with a medical examiner or funeral director.
- * Worker's compensation purposes.
- * Scheduling an interpreter for you.
- * In the event of a disaster.
- * Preventing or controlling outbreaks of disease.
- * Reporting births or deaths.
- * In the event of a healthcare emergency.
- * In the event of an eminent threat to self or others.
- * Complying with court or administrative orders, or in response to a subpoena.
- * Reporting suspected abuse, neglect or domestic violence.
- * Responding to an investigation or audit conducted by a health oversight agency.
- * To correctional facilities as necessary for your care.
- * For national security or to protect the President.

➤ **Please see back of document for Privacy Complaint resources**

Your privacy rights

- * You can ask us to limit how we use or share your information. You must ask in writing. We can agree if law allows.
- * You can ask us to contact you in a certain way or in a certain place. We will follow any realistic request.
- * In most cases, you can look at or get copies of your records. You must ask in writing. You may have to pay for the copies. Please contact us for the form.
- * You can ask to amend health information in your medical or billing records. This must be in writing. We may not agree to these changes in certain situations.
- * You can ask for a list of those with whom we have shared your PHI in the past 6 years. You must ask in writing. This list will not include disclosures of PHI made for treatment, payment, or health care operations, or those that were made pursuant to your written authorization.
- * You can usually revoke your written authorization if you ask us in writing. However, we can't take back any PHI or other information we have already shared.
- * Your PHI will not be sold.
- * Genetic information cannot be disclosed to health plans to determine eligibility.
- * We will not disclose information to your health plan if you pay for services out of pocket.
- * You can ask for a paper copy of this Notice at any time.
- * You can choose to designate someone as your authorized representative for purposes of deciding whether your PHI should be shared. Any such designation must be in writing and otherwise legally valid.

Your Choices

You have some choices in the way we use and share your PHI in the following circumstances:

- * To tell family or friends about your condition.
- * To provide disaster relief.
- * To include you in a mental health or hospital directory.
- * To market our services or sell your information.
- * To raise funds.

If you have a preference as to how we share PHI in any of these circumstances, please tell us and we will follow your instructions to the extent we are legally able to do so.

OCHIN

Deschutes County Health Services is a member of OCHIN, an organized health care arrangement. OCHIN supplies information technology, electronic records management and related services to Deschutes County Health Services and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. Deschutes County Health Services may share your PHI with other OCHIN participants when necessary for health care operations purposes of the organized health care arrangement. A current list of OCHIN members is available at <http://www.ochin.org/our-members/ochin-members/>

RELIANCE

RELIANCE Health Information Exchange is a business associate of Deschutes County Health Services. RELIANCE provides secure, electronic exchange of health information among authorized members in the health care community – such as health care providers and public health agencies – to drive timely, efficient and patient-centered care. Deschutes County Health Services may share your PHI with RELIANCE for the purposes of facilitating the exchange of health information among authorized RELIANCE members for treatment, payment or healthcare operations purposes. A current list of Reliance members is available at <http://reliancehie.org/frequently-asked-questions/>

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PRIVACY COMPLAINTS

We care about your concerns! If you do not agree with how we used or disclosed health information about you, you may file a complaint. You will not be punished and your care will not be affected. **TO FILE A PRIVACY COMPLAINT, PLEASE CONTACT ONE OF THE FOLLOWING:**

Deschutes County Health Services
Attn: Division Privacy Officer
2577 NE Courtney Drive, Bend, OR 97701
Health Services – 541-322-7607 Fax: 541-322-7567

Office for Civil Rights
U.S. Department of Health and Human Services, Region 10 HHS
2201 6th Avenue, Seattle, WA 98121-1831
Voice Phone (206) 615-2290
FAX (206) 615-2297; TDD (206) 615-2296



Deschutes County Behavioral Health (DCHS) Client Grievances/Complaints

Client grievances are used as an important source of information for continuously improving services. Every client has the right to file grievances in accordance with applicable rules and regulations. If you have a problem with access, service, clinical care, contact with staff, quality of care, or your rights, please let us know.

Grievance Appeal Process:

1. You, your family, or authorized representatives have the right to appeal a grievance decision. Grievance appeals must be sent to the Health Systems Division of the Oregon Health Authority within ten (**10**) business days of notification of the grievance decision.
 - a. Quality Improvement Specialist or DCHS staff will be available to assist you in the appeals process if requested.
2. Appeals will be reviewed and responded to in writing by the Health Systems Division of the Oregon Health Authority within ten (10) business days of receipt of the appeal.
3. You, your family, or authorized representatives also have the right to file a second appeal if you are dissatisfied with the result of the first appeal. Second appeals must be submitted within ten (**10**) business days of notification of the first appeal decision and must be reviewed and responded to by the Health Systems Division of the Oregon Health Authority Director within ten (**10**) business days of receipt of the second appeal.

Expedited Grievance Process:

1. In circumstances where the matter of the grievance is likely to cause harm to you or another before the grievance process as outlined above will be completed, you may request an expedited grievance review. Expedited grievances will be reviewed by the appropriate Program Manager within 48 hours of receipt of the grievance. A written response including information about the appeals process will be issued to you.

For Additional Questions or Concerns:

Channing Casey, RN, Quality Improvement Specialist

Channing.Casey@deschutes.org

(541) 330-4600



**Deschutes County Behavioral Health (DCHS)
Client Grievances/Complaints**

**Deschutes County Health Services
Grievance Form EXAMPLE**

PLEASE PRINT LEGIBLY

Deschutes County Health Services wants to give you the best care possible. Therefore, suggestions for improvement or concerns about services are welcomed. Please complete this form, including your complete name, signature, and date. The back of this form is for office use only.

Date of Grievance: _____

Name (first/last): _____ **Phone:** _____

Address: _____

Birthdate: _____ **Oregon Health Plan:** Yes No **EHR #:** _____

Program: _____

Staff Involved: _____

Describe the Grievance (provide details about concerns): _____

Signature of Person Completing Report: _____ **Date:** _____

Return to one of the following: Your counselor, a supervisor, a manager, front desk staff, or to a quality improvement specialist. This form may be submitted by mail to: Attention: QM Department, 2577 NE Courtney Dr, Bend OR 97701. You will be contacted within two business days after the form has been received.



DESCHUTES COUNTY BEHAVIORAL HEALTH PATIENT INFORMATION

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.

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.

By: _____
Patient or Patient's Authorized Personal Representative

Date: _____

By: _____
DCHS Employee Signature

Date: _____