





# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

MRN \_\_\_\_\_

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

## LIVING ARRANGEMENT

Please choose which best describes your living situation

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Homeless                    | <input type="checkbox"/> Foster Home                         | <input type="checkbox"/> Residential Facility/Group Home         |
| <input type="checkbox"/> Jail                        | <input type="checkbox"/> Prison                              | <input type="checkbox"/> Room and Board                          |
| <input type="checkbox"/> Supportive Housing          | <input type="checkbox"/> Supportive Housing (scattered site) | <input type="checkbox"/> Supportive Housing (Congregate Setting) |
| <input type="checkbox"/> Alcohol/Drug Free Housing   | <input type="checkbox"/> Oxford Home                         | <input type="checkbox"/> Other Private Residence                 |
| <input type="checkbox"/> Private Residence (Home)    | <input type="checkbox"/> Private Residence (relative)        | <input type="checkbox"/> Private Residence (non-relative)        |
| <input type="checkbox"/> Residential Facility (SUD)  | <input type="checkbox"/> Residential Facility (BRS)          | <input type="checkbox"/> Residential Facility (CSEC)             |
| <input type="checkbox"/> Residential Facility (PRTS) | <input type="checkbox"/> Residential Facility (SCIP/SAIP)    | <input type="checkbox"/> Residential Facility ( SRTF for YAT)    |
| <input type="checkbox"/> Unknown                     |  |  |

## RACE AND ETHNICITY

Race (Please mark all that apply)

- Alaska Native  
 Black/African American     Asian  
 Hawaiian/Pacific Island     Other  
 American Indian     Single race  
 Two or more races  
 White/Caucasian

Ethnicity (Please mark all that apply)

- Hispanic     Central American  
 Puerto Rico     Cuban  
 Non-Hispanic     Mexican  
 Other Specific     Unknown  
 Other:

Tribal Affiliations (Please mark all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Burns Paiute Tribe                  | <input type="checkbox"/> Confederated Tribes of Coos, Lower Umpqua & Siuslaw |
| <input type="checkbox"/> Confederated Tribes of Grand Ronde  | <input type="checkbox"/> Confederated Tribes of Siletz                       |
| <input type="checkbox"/> Confederated Tribes of the Umatilla | <input type="checkbox"/> Confederated Tribes of Warm Springs                 |
| <input type="checkbox"/> Coquille Indian Tribe               | <input type="checkbox"/> Cow Creek Band of Umpqua Indians                    |
| <input type="checkbox"/> Klamath Tribes                      | <input type="checkbox"/> Not Applicable                                      |
| <input type="checkbox"/> Other (Please describe):            |  |



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## LEGAL STATUS

Please choose which best describes your situation

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> DUII Diversion Client   | <input type="checkbox"/> DUII Convicted Client        | <input type="checkbox"/> 30 Day Civil Commitment                 |
| <input type="checkbox"/> 90 Day Civil Commitment | <input type="checkbox"/> 180 day Civil Commitment     | <input type="checkbox"/> Incarcerated                            |
| <input type="checkbox"/> Parole                  | <input type="checkbox"/> Probation                    | <input type="checkbox"/> Psychiatric Services Review Board(PSRB) |
| <input type="checkbox"/> Juvenile PSRB           | <input type="checkbox"/> Guardianship (Child Welfare) | <input type="checkbox"/> Guardianship (Court)                    |
| <input type="checkbox"/> Aid and Assist          | <input type="checkbox"/> None                         | <input type="checkbox"/> Involuntary Custody                     |
| <input type="checkbox"/> Unknown                 |   |  |

## 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

Do you also want help with

- Education  Employment  Housing  Other

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

## Reason For Seeking Services



# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

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## FINANCIAL INFORMATION

### HEALTH INSURANCE

Name of Individual Seeking Services	Name of Responsible Party
Responsible Party Place of Employment	Responsible Party Employer Address
Responsible Party Work Phone	Policy Holder Name
Primary Health Insurance Plan ID #*(OHP, Medicare, etc.)	Policy Holder DOB*(Required if not self)
Secondary Health Insurance Plan ID #	Other Health Insurance Plan ID #

### EMPLOYMENT STATUS

Please choose the one that best describes your employment status		
<input type="checkbox"/> Full Time	<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired
<input type="checkbox"/> Part Time	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Not in Labor Force
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Student	<input type="checkbox"/> Other (volunteer etc.)
<input type="checkbox"/> Hospital Patient, Incarcerated or Other Residential Institution	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Sheltered Employment (Opportunity Foundation, Good Will, etc.)		

### 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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## FINANCIAL INFORMATION

### HOUSEHOLD MEMBERS AND DEPENDENTS

List name(s) and DOB of household members

Self	DOB	Dependent	DOB
Spouse/Partner	DOB	Dependent	DOB
Guardian/Parent	DOB	Dependent	DOB
Guardian/Parent	DOB	Dependent	DOB

- ❖ 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**)

<b>STAFF VERIFICATION CHECKLIST (attach copies)</b>		
Proof of ID: Photo ID, Drivers License, Birth Certificate, Social Security Card	Co-pay amount:	
	Fee amount:	
OHP, T-19, Medicaid Application or rejection letter	Effective Date	
Staff Signature Line-please sign after explaining financial and sliding fee scale to responsible party	Date of staff signature	
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 BEHAVIORAL HEALTH APPLICATION FOR SERVICE

## 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:	
<input type="checkbox"/> Major accidents <input type="checkbox"/> Drug overdose <input type="checkbox"/> Kidney problems <input type="checkbox"/> Skin infections <input type="checkbox"/> High blood pressure <input type="checkbox"/> Mental Health Hospitalization <input type="checkbox"/> Rash <input type="checkbox"/> Hallucinations <input type="checkbox"/> Severe drug/ alcohol withdrawal <input type="checkbox"/> Physical/Emotional/Intellectual/Developmental Disability	<input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma or breathing problem <input type="checkbox"/> Neurological problems <input type="checkbox"/> Sexually transmitted infection <input type="checkbox"/> Liver problems <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Hepatitis (A,B or C) <input type="checkbox"/> Head injury
<input type="checkbox"/> Eating disorder <input type="checkbox"/> GI bleeding <input type="checkbox"/> Ulcer <input type="checkbox"/> Heart murmur <input type="checkbox"/> Lung or Pulmonary disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Seizures or convulsions	
Allergies to medications (Please list)	
Other issues not listed above (Please list)	
Explain any of the checked above that you have experienced <b><u>within the last 6 months</u></b>	
Approximate dates for major accidents/injuries, illnesses and mental health hospitalizations	
Do you currently have a doctor <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
If yes, name of Doctor	
Last date you saw your doctor	
Are you currently taking any medication <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
If yes, please list medications and dosages	
Nicotine/Tobacco use <input type="checkbox"/> Yes <input type="checkbox"/> No Amount per day	Are you interested in cutting back/quitting <input type="checkbox"/> Yes <input type="checkbox"/> No Would you like a Tobacco Quit Line referral <input type="checkbox"/> Yes <input type="checkbox"/> No
Any substance/drug use during the last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Are you pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If yes, due date



# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

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## 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

Date



# DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

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 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.**

By: \_\_\_\_\_  
*Patient or Patient's Authorized Personal Representative*

Date: \_\_\_\_\_

By: \_\_\_\_\_  
*DCHS Employee Signature*

Date: \_\_\_\_\_



**AUTHORIZATION FOR USE AND DISCLOSURE OF  
PERSONAL HEALTH INFORMATION**

Legal Last Name of Client:	First:	MI:	Date of Birth:
----------------------------	--------	-----	----------------

Other names used by Client:
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By signing this form, I authorize the following record holder to disclose the following specific confidential information about Client:

RECORD HOLDER	Record Holder's Identity:	Specific information to be disclosed: (include date range if applicable):	*Mutual Exchange: Yes/No
RECORD HOLDER			
RECORD HOLDER			
RECORD HOLDER	<p>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:</p> <p>HIV/AIDS: _____   Mental Health (except psychotherapy notes): _____   Genetic Testing Information: _____</p> <p>Alcohol/drug diagnoses, treatment, referral: _____</p> <p><b>*Mutual exchange allows information to be released back and forth between the record holder(s) and the recipient(s).</b></p>		

RECIPIENT	Release to: (address required if information is to be mailed to recipient). If releasing to a team, list members.	Purpose of release:	Expiration date or event:**
RECIPIENT			
RECIPIENT			

ACKNOWLEDGEMENT	<p><b>**This authorization is valid for one year from the date of signing unless otherwise specified.</b></p> <p>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. <b>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.</b></p> <p>I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected under federal or state law, EXCEPT THAT redisclosure 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.</p> <p>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."</p>
ACKNOWLEDGEMENT	

SIGNATURE	Full legal signature of individual or authorized personal representative	Relationship to Client:	Date:
SIGNATURE	X		
SIGNATURE	Print Name of Person Signing This Authorization	This is a true copy of the original authorization document	



## 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;



## Deschutes County Health Services RIGHTS AND RESPONSIBILITIES

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

## RIGHTS AND RESPONSIBILITIES

### 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;
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 made 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 DCHS Director 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 DCHS 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](mailto: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):** \_\_\_\_\_

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**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 APPLICATION FOR SERVICE

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