



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 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: _____ **Client's Date of Birth:** _____

Signature: _____ **Date:** _____
Client, guardian or authorized personal representative

Print Name if signed by someone other than client: _____



DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

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 chose not to accept 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 chose not to accept the Client Information Packet, additional information, or assistance

Individual or Caregiver Signature

Date



DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

CHILD 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 Individual's identified gender?		<input type="checkbox"/> Gender non binary, neither exclusively male nor female		
<input type="checkbox"/> Female		<input type="checkbox"/> Female-to-male (FTM)/Transgender Male/Trans Man		
<input type="checkbox"/> Male		<input type="checkbox"/> Male-to-Female (MTF)/Transgender Female/Trans Woman		
<input type="checkbox"/> Two Spirit		<input type="checkbox"/> Questioning		
<input type="checkbox"/> Additional gender category/ (or Other), please specify: _____				
What sex was assigned at birth on Individual's original birth certificate?			Pronouns (She, He, They, Other):	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Choose not to disclose			Preferred Name:	
Contact information: <i>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.</i>				
Cell Phone:		OK to text: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Individual's Phone <input type="checkbox"/> Parent/Guardian's Phone		OK to leave detailed voicemail: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Home Phone:		OK to leave detailed voicemail: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Phone:		OK to leave detailed voicemail: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email Address:		OK to send non-secure emails: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Individual's Email <input type="checkbox"/> Parent/Guardian's Email				
Street/Physical Address		City	State	Zip
Mailing/Secondary Address (if different)		City	State	Zip
County of Residence		Individual resides with: <input type="checkbox"/> 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

CHILD APPLICATION

MRN _____

EMERGENCY CONTACT				
First and Last Name of Emergency Contact:				
Relationship	Address	City	State	Zip
*Emergency Information Can we leave a message (Please choose): <input type="checkbox"/> Yes <input type="checkbox"/> No Phone # _____				

Custody Attestation
<p>For a child under the age of 14, please attest to one of the following below: The adult person seeking to register the child for DCBH services is: _____. This person is legally authorized to obtain medical and mental health services for the child because (select which option applies):</p> <p><input type="checkbox"/> The person is a legal parent of the child, and the person’s parental rights regarding the child, including custodial rights, have not been restricted in any way.</p> <p><input type="checkbox"/> The person is a legal parent of the child and has been awarded legal custody of the child by court order.</p> <p><input type="checkbox"/> The person is not a legal parent of the child but has been awarded legal custody or guardianship of the child by court order or appointment.</p> <p><input type="checkbox"/> Other. If none of the above apply, but you believe you are authorized to obtain medical and/or mental health services for the child, please explain the basis for your belief: _____</p> <p>Should the accuracy of the above attestation be brought into question at any time in the future, or for any other reason, DCHS may demand legal documentation supporting such attestation.</p>

MARITAL STATUS		
<input type="checkbox"/> Married <input type="checkbox"/> Significant Other <input type="checkbox"/> Single <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Other	Name of spouse/partner (if applicable):

LIVING ARRANGEMENT		
Please choose which best describes Individual’s living situation:		
<input type="checkbox"/> Homeless <input type="checkbox"/> Jail <input type="checkbox"/> Supportive Housing <input type="checkbox"/> Alcohol/Drug Free Housing <input type="checkbox"/> Private Residence (Home) <input type="checkbox"/> Residential Facility (SUD) <input type="checkbox"/> Residential Facility (PRTS) <input type="checkbox"/> Unknown <input type="checkbox"/> Residential Facility (RTH for YAT)	<input type="checkbox"/> Foster Home <input type="checkbox"/> Prison <input type="checkbox"/> Supportive Housing (scattered site) <input type="checkbox"/> Oxford Home <input type="checkbox"/> Private Residence (relative) <input type="checkbox"/> Residential Facility (BRS) <input type="checkbox"/> Residential Facility (SCIP/SAIP) <input type="checkbox"/> Secure Residential (SRTF Adult)	<input type="checkbox"/> Residential Facility/Group Home <input type="checkbox"/> Room and Board <input type="checkbox"/> Supportive Housing (Congregate Setting) <input type="checkbox"/> Other Private Residence <input type="checkbox"/> Private Residence (non-relative) <input type="checkbox"/> Residential Facility (CSEC) <input type="checkbox"/> Residential Facility (SRTF for YAT) <input type="checkbox"/> Residential Sub-Acute Care Facility



DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

CHILD APPLICATION

MRN _____

RACE AND ETHNICITY

Race/Ethnicity (Please mark all that apply):

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Black/African American | <input type="checkbox"/> American Indian | <input type="checkbox"/> Asian Indian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Chinese | <input type="checkbox"/> Mexican | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Samoan | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Mexican American | <input type="checkbox"/> Cuban | <input type="checkbox"/> Other | <input type="checkbox"/> Non-Hispanic or Latino/a |
| <input type="checkbox"/> Chicano/a | <input type="checkbox"/> Two or more races | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Patient Refused | <input type="checkbox"/> Multiple Hispanic, Latino/a, or | <input type="checkbox"/> Single Race | |
| <input type="checkbox"/> Another Hispanic Latino/a or Spanish Origins | | | |

Spanish Origin

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): | |

LEGAL STATUS

Please choose which best describes Individual's 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"/> Involuntary Custody | <input type="checkbox"/> Pre-Arrest Jail Diversion |
| <input type="checkbox"/> Post-Arrest Jail Diversion | <input type="checkbox"/> Unknown | <input type="checkbox"/> None |

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

Has Individual 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



DESCHUTES COUNTY BEHAVIORAL HEALTH APPLICATION FOR SERVICE

CHILD APPLICATION

MRN _____

FINANCIAL INFORMATION

The information on this form is used to determine eligibility for our sliding fee discount program.

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 Individual's 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.)
Do you want help with employment? <input type="checkbox"/> Yes or <input type="checkbox"/> No

INCOME					
<i>The information on this form is used to determine eligibility for our sliding fee discount program</i>					
Monthly household income sources	Individual	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

CHILD APPLICATION

MRN _____

FINANCIAL INFORMATION

HOUSEHOLD MEMBERS AND DEPENDENTS			
<i>The information on this form is used to determine eligibility for our sliding fee discount program</i>			
List number of household members living with Individual in each category			
Individual	Spouse/Partner	Parent/Guardian	Dependents
1			
<ul style="list-style-type: none"> ❖ 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. ❖ <u>I will notify DCBH promptly of any change to the above information.</u> 			
Responsible Party Signature		Date	
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	

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
	Expiration date



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:** _____

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"/> Diabetes
<input type="checkbox"/> Drug overdose	<input type="checkbox"/> Asthma or breathing problem
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Neurological problems
<input type="checkbox"/> Skin infections	<input type="checkbox"/> Sexually transmitted infection
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Liver problems
<input type="checkbox"/> Mental Health Hospitalization	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Rash	<input type="checkbox"/> Cardiac disease
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Hepatitis (A, B or C)
<input type="checkbox"/> Severe drug/ alcohol withdrawal	<input type="checkbox"/> Head injury
<input type="checkbox"/> Physical/Emotional/Intellectual/Developmental Disability	<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 <u>within the last 6 months</u>	
Approximate dates for major accidents/injuries, illnesses and mental health hospitalizations	
Do you currently have a doctor <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of Doctor _____	Last date you saw your doctor _____
Are you currently taking any medication <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list medications and dosages _____	
Nicotine/Tobacco use <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you interested in cutting back/quitting <input type="checkbox"/> Yes <input type="checkbox"/> No
Amount per day _____	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 _____