Acknowledgement of Orientation Documents and Consent for Treatment

Acknowledgement of Orientation Packet:

By signing this form, you acknowledge you have received or declined a copy of the following information from Polk County Behavioral Health. We encourage you to review all documents in the Orientation Packet carefully. If you have declined a paper copy, you may visit our website at **https://www.co.polk.or.us/bh** to review materials online. The Orientation Packet contains the following information:

- Overview of Services
- Client Rights and Responsibilities
- Information about Complaints and Grievances
- Notice of Privacy Practices

_____ I received a paper copy of the Orientation Packet

_____ I declined a paper copy of the Orientation Packet, but have reviewed all documents.

Consent for Treatment

By agreeing to receive services from Polk County Behavioral Health, I acknowledge the risks and benefits of treatment include, but are not limited to, the following:

Benefits

- Determining my strengths and goals for treatment
- Choosing which goals are priorities and working with my therapist in deciding how to reach those goals
- Having the opportunity to become more independent
- Enjoying increased satisfaction with the quality of my life
- Developing a personalized plan to address safety or crisis situations
- Experiencing an increase in positive responses to difficult situations
- Improving my coping abilities and reducing my stress
- Improving my personal relationships

Risks

- Experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness and helplessness
- Being in touch with painful emotions, sometimes for the first time, which may temporarily lead to feeling worse
- Recalling or talking about unpleasant aspects of my life, which can bring up uncomfortable feelings
- Personal growth sometimes requires changes that may be uncomfortable or unexpected
- Significant others may notice the changes I make; my relationships with others may be affected by the changes I make
- I may not achieve my desired level of improvement.

I understand that I have the right to refuse or stop treatment at any time. I understand that refusal or stopping treatment may have an effect on my condition, it may worsen, stay the same, or get better. I give permission to Polk County Behavioral Health to provide treatment and services to me, my child, or the person I am the legal guardian of.

_____ _____ _____

Print Name of Client | Print Name of Legal Guardian if applicable | Date

FOR OFFICE USE ONLY Client ID: _____

FINANCIAL AGREEMENT AND CONSENT

I agree to be financially responsible and pay for the services that are not fully covered by insurance. I understand that the law allows Polk County Behavioral Health to collect from me the amount owing.

I authorize Polk County Behavioral Health to use, disclose and communicate both verbally and in writing my health information, including substance use and mental health information to and from my health insurance company or other entity responsible for my medical bills for the purpose of eligibility, payment, audit and health care operations.

I hereby assign Polk County Behavioral Health all monies to which I am entitled from insurance for services received.

Print Name of Client	Signature: ☐Client -or- ☐Legal Guardian	Date

FOR OFFICE USE ONLY Client ID: _____

Behavioral Health Registration

Please fill out the following information for the person who will be receiving services.
If you require assistance completing any portion of the forms, please let an office staff know.
Thank you!

What Services Are You Seeking?

☐ Mental Health Counseling ☐ Alcohol & Drug Treatment ☐ DUII Program ☐ Other: _____

CLIENT'S INFORMATION

Last Name	First Name	Middle Initial

Social Security No. - -	ODL/Oregon DMV# (required if seeking DUII related services)	Date of Birth / /

Street Address	City	State	Zip Code

Mailing Address (if different from Street Address)	City	State	Zip Code

If Client is a Minor (under the age of 18):

Parent / Legal Guardian Name: _____

Parent / Legal Guardian Name: _____

A minor who is 14 years or older may access outpatient mental health, drug or alcohol treatment without parental consent.

- We ask for parent/guardian information because unless there are safety concerns, parents are expected to be involved in their minor child's treatment at some point.
- Involvement does not mean that adults always have access to a minor's mental health or chemical dependency records.
- Federal regulation 42 CFR 2.14 states that if a minor is able to self-consent for drug or alcohol treatment, the minor's treatment records cannot be disclosed without the minor's written consent (including to the parent or guardian).

CLIENT INSURANCE INFORMATION

Oregon Health Plan (OHP) ID #	Health Plan Name

Medicare ID #	Coverage ☐ Part A ☐ Part B ☐ Part D Name:

Additional Health Insurance Plan	Group No.	ID #	Insurance Phone Number

Responsible Party (if different than insured)	Relationship	Date of Birth / /	Phone Number

Additional Insurance provided through: ☐ Employer ☐ Self Purchased ☐ Absent Parent

☐ Other: _____

COMMUNICATION

Home Phone #	May we leave messages on this phone?	☐ Yes ☐ No
Cell Phone #	May we leave messages on this phone?	☐ Yes ☐ No
	May we send text messages regarding appointments to this phone?	☐ Yes ☐ No
Email	May we send email messages regarding appointments to this phone?	☐ Yes ☐ No

What is your preferred method for appointments?

- ☐ I prefer to attend appointments IN PERSON
- ☐ I prefer appointments through VIDEO
- ☐ I don't have a preference – either IN PERSON or VIDEO is fine with me

We will make every effort to accommodate your preferences, however it may not always be guaranteed.

HEALTH INFORMATION

Mark if you have recieved the following services in the past. *Please indicate if we may request these records*

ROI for Records Request

- ☐ Mental Health Counseling Provided By: _____ ☐ Yes ☐ No
- ☐ Alcohol and Drug Treatment Provided By: _____ ☐ Yes ☐ No
- ☐ Psychiatric Medication Management Provided By: _____ ☐ Yes ☐ No

Primary Care Provider – Who provides your Medical Care?

Dr. Name: _____ Clinic Name/Location:_____

Are you pregnant? ☐Yes ☐No	Do you use tobacco? ☐Yes ☐No	Do you use alcohol? ☐Yes ☐No
Do you use drugs recreationally? ☐Yes ☐No	Do you use illegal drugs? ☐Yes ☐No	
Do you use IV Drugs? ☐Yes ☐No	Have you used non-prescribed drugs or alcohol in the past 90 days? ☐Yes ☐No	

ADVANCE DIRECTIVES

Have you previously completed an Advance Directive?

- ☐ No - I have not completed an Advance Directive
- ☐ Yes - I have a completed Advance Directive and it is on file with:
  - ☐ PCP _____
  - ☐ Hospital: _____
  - ☐ Family, Attorney, Personal Representative _____

MEDICATIONS / ALLERGIES

Do you have any Allergies to Medication? ☐ Yes ☐ No

If so, please list:

_____

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If you are currently being prescribed any of the following medications, please mark below:

Medications	Who prescribes you this medication?	Medications	Who prescribes you this medication?
Antipsychotics		**ADHD - nonstimulant**	
☐ olanzapine/Zyprexa		☐ atomoxetine/ Strattera	
☐ risperidone/ Risperdal		☐ clonidine/ Catapres/Kapvay	
☐ clozapine/ Clozaril		☐ guanfacine / Tenex/ Intuniv	
☐ aripiprazole/ Abilify		☐ bupropion/ Wellbutrin	
☐ quetiapine/ Seroquel		**Antidepressants**	
☐ chlorpromazine/ Thorazine		☐ fluoxetine/Prozac	
☐ haloperidol/Haldol		☐ citalopram/ Celexa	
☐ ziprasidone/Geodon		☐ sertraline/ Zoloft	
☐ paliperidone/ Invega		☐ escitalopram/ Lexapro	
☐ asenapine/ Saphris		☐ bupropion/ Wellbutrin	
☐ lurasidone/Latuda		☐ paroxetine/ Paxil	
☐ cariprazine/Vraylar		☐ mirtazapine/ Remeron	
Benzodiazepines		☐ duloxetine/ Cymbalta	
☐ lorazepam/ Ativan		☐ venlafaxine/ Effexor XR	
☐ clonazepam/ Klonopin		☐ desvenlafaxine / Pristiq	
☐ diazepam/ Valium		☐ levomilnacinpran/ Fetzima	
☐ alprazolam/ Xanax		☐ vortioxetine/ Trintellix	
☐ chlordiazepoxide/ Librium		☐ vilazodone/ Viibryd	
☐ temazepam/restoril		**Other**	
☐ flurazepam/Dalmane		☐ Vicodin	
ADHD- Stimulant		☐ Oxycontin	
☐ Adderall XR		☐ Fentanyl/Duragesic/Fentora	
☐ Adderall		☐ Lorcet/Lortab/ Norco	
☐ Concerta		☐ Hydromorphone/Dilaudid	
☐ Dexadrine		☐ Merperidine/Demerol	
☐ Daytrana		☐ Methadone/Dolophine	
☐ Focalin XR		☐ Morhpine/MS contin	
☐ Quillivant XR		☐ Oxycodone	
☐ Ritalin		☐ Oxyfast/Roxicodine	
☐ Ritalin SR		☐ Targiniq ER	
☐ Vyvanse		☐ Percocet	
☐ Metadate ER		☐ Tramadol	
☐ Metadate CD		☐ Suboxone	
☐ Methylin ER		☐ Other:	
☐ Jornay			

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DEMOGRAPHICS

Because we are a Medicaid provider, we are required to ask the following questions. The Oregon Health Authority uses information collected to better understand the needs and background of people who we serve. This information also helps them make decisions about future programs that they will develop and fund.

1. **How do you (the client) identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?**

_____

2. **Which of the following describes your (the client's) racial or ethnic identity?** (Please check ALL that apply)

☐ **I don't want to answer**

HISPANIC AND LATINO a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

NATIVE HAWAIIAN AND PACIFIC ISLANDER
- ☐ Chamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

WHITE
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

AMERICAN INDIAN AND ALASKA NATIVE
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

2a. What is the client's Tribal Affiliation
- ☐ Not Applicable
- ☐ Burns Paiute
- ☐ Conf Tribe Coos, Lower Ump & Siuslaw
- ☐ Conf Tribe of Grand Ronde
- ☐ Conf Tribe of Siletz
- ☐ Conf Tribe of Umatilla
- ☐ Conf Tribe of Warm Springs
- ☐ Coquille Indian Tribe
- ☐ Cow Creek / Ump Indians
- ☐ Klamath Tribes
- ☐ Other

BLACK / AFRICAN AMERICAN
- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

MIDDLE EASTERN/NORTH AFRICAN
- ☐ Middle Eastern
- ☐ North African

ASIAN
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asia

2b. Which of the following best describes your (the client's) ethnicity:

☐ I don't want to answer ☐ Not of Hispanic Origin ☐ Hispanic ☐ Cuban ☐ Mexican ☐ Puerto Rican
☐ Other Specific Hispanic_____

3. If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ Yes. Please type your primary racial or ethnic identity:_____
- ☐ I do not have just one primary racial or ethnic identity
- ☐ No. I identify as Biracial or Multiracial
- ☐ N/A. I only checked one category above
- ☐ Don't know
- ☐ Don't want to answer

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Received By: Client ID#

4a. What language or languages do you use at home? ☐ English ☐ Spanish ☐ Other_____

* *Skip to question 7 if you indicated English only*

4b. In what language do you want us to communicate in person, on the phone, or virtually with you?

☐ English ☐ Spanish ☐ Other_____

4c. In what language do you want us to write to you? ☐ English ☐ Spanish ☐ Other_____

5a. Do you need or want an interpreter for us to communicate with you? *(Interpreters are available at no charge)

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

☐ Spoken language interpreter
☐ Deaf Interpreter for DeafBlind, additional barriers, or both
☐ American Sign Language interpreter
☐ Contact sign language (PSE) interpreter
☐ Other (please list): _____

* *Skip to question 7 if you do not use a language other than English or sign language*

6. How well do you speak English?

☐ Very Well ☐ Well ☐ Not Well ☐ Not at all ☐ Don't know ☐ Don't want to answer

7. Are you deaf or do you have serious difficulty hearing?

☐ Yes, please indicate the age at which the condition began _____ ☐ No ☐ Don't Know ☐ Don't Want to Answer

8. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

☐ Yes, please indicate the age at which the condition began _____ ☐ No ☐ Don't Know ☐ Don't Want to Answer

* *Please skip to question 17 now if the client is under age 5*

9. Do you have serious difficulty walking or climbing stairs?

☐ Yes, please indicate the age at which the condition began _____ ☐ No ☐ Don't Know ☐ Don't Want to Answer

10. Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?

☐ Yes, please indicate the age at which the condition began _____ ☐ No ☐ Don't Know ☐ Don't Want to Answer

11. Do you have difficulty dressing or bathing?

☐ Yes, please indicate the age at which the condition began _____ ☐ No ☐ Don't Know ☐ Don't Want to Answer

12. Do you have serious difficulty learning how to do things most people your age can learn?

☐ Yes, please indicate the age at which the condition began _____ ☐ No ☐ Don't Know ☐ Don't Want to Answer

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Received By: Client ID#

13. Using your usual (customary) language, do you have serious difficulty communicating (for example understanding or being understood by others)?

- ☐ Yes, please indicate the age at which the condition began _____
- ☐ No
- ☐ Don't Know
- ☐ Don't Want to Answer
- ☐ Don't Know what this question is asking

* ***Please skip to question 17 now if the client is under age 15***

14. Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

☐ Yes, please indicate the age at which the condition began _____ ☐ No ☐ Don't Know ☐ Don't Want to Answer

15. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?

- ☐ Yes, please indicate the age at which the condition began _____
- ☐ No
- ☐ Don't Know
- ☐ Don't Want to Answer
- ☐ Don't Know what this question is asking

16. How do you describe your sexual orientation or sexual identity?

- ☐ Don't Know what this question is asking
- ☐ I don't want to answer
- ☐ Don't know
- ☐ Straight (attracted mainly to or only to other gender(s) or sex(s))
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Pansexual
- ☐ Asexual
- ☐ Queer
- ☐ Same-gender loving
- ☐ Same-sex loving
- ☐ Questioning

17. Client last name at birth? (on birth certificate) _____

18. What is your Gender Identity? ☐ Female ☐ Male ☐ Trans Woman ☐ Trans Man ☐ Non-Binary

18a. What sex were you assigned at birth (on your original birth certificate)? ☐ Female ☐ Male

19. Is the client a veteran?

- ☐ Yes, Veteran and Current or Former Active Duty Military
- ☐ Yes, Veteran and Current or Former Guard/Reserve Military
- ☐ No, but Current or Former Guard/Reserve Military
- ☐ No

20. What is the highest grade (year) completed by client? _____

20a. If currently a student, what school do you attend? _____

21. What is client's county of residence? ☐ Polk ☐ Marion ☐ Other: _____

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Received By: Client ID#

22. What is client's marital status? (If Living as Married – Please check married)

☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

23. What is client's employment status (check all that apply)?

☐ Full Time (35 or more hours)
☐ Part Time (Less than 35 hours)
☐ Unemployed (Looking for work or on layoff)
☐ Homemaker
☐ Student
☐ Retired
☐ Disabled (Unable to work for physical or psychological reasons)
☐ Hospital Patient or Resident of Other Institutions
☐ Other Reported Classification (e.g. volunteers)
☐ Sheltered/Non-Competitive Employment (Jobs in segregated settings for a specific population, intended to provide training and experience)
☐ Not in Labor Force (Not actively looking for work)

23a. Are you interested in receiving information about how to find employment? ☐ Yes ☐ No

24. What is the primary source of income/support for client or parent(s) of client?

☐ Wages/Salary ☐ Disability/SSDI ☐ Other
☐ Public Assistance ☐ Retirement/Pension/SSI ☐ None

25. Estimated Gross Monthly Household Income: $_____ ☐ No Income ☐ Refuse to Answer

26. What is the total number of people dependent upon the Household income? _____

26a. How many of these are ages 0-17? _____

27. What is the client's living arrangement?

☐ Private Residence (at home)
☐ Private Residence (with Relatives)
☐ Private Residence (with non-relative)
☐ Other Private Residence
☐ Transient/Homeless
☐ Foster Home
☐ Residential Facility
☐ Jail
☐ Prison
☐ Room & Board
☐ Supported Housing
☐ Supported Housing (scattered site)
☐ Supported Housing (congregate setting)
☐ Alcohol and Drug Free Housing
☐ Oxford Home
☐ Residential Facility (SUD)
☐ Residential Facility (BRS)
☐ Residential Facility (CSEC)
☐ Residential Facility (PRTS)
☐ Residential Facility (SCIP/SAIP)
☐ Residential Facility (SRTF or YAT)
☐ Residential Facility (RTH or YAT)
☐ Secure Residential (SRTF Adult)
☐ Residential Sub-Acute Care Facility
☐ Other _____

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Received By: Client ID#

28. Please list the number of:

Total Arrests in the **past MONTH** _____ Total Arrests in **your LIFETIME** _____
DUII arrests in the **past MONTH** _____ DUII arrests in **your LIFETIME** _____

29. Who Referred You To Us?

- ☐ Self
- ☐ Child Welfare
- ☐ Crisis Helpline
- ☐ ADSS
- ☐ Parole
- ☐ Probation
- ☐ School
- ☐ Circuit Court
- ☐ Federal Court
- ☐ Municipal Court
- ☐ Advocacy Court
- ☐ Aging & Disability
- ☐ Attorney
- ☐ DD Services
- ☐ Doctor, Nurse or Physician
- ☐ Family/Friend
- ☐ Media, Internet
- ☐ Police or Sheriff
- ☐ Employer
- ☐ Employment Services
- ☐ Vocational Rehab
- ☐ Health Plan/CCO
- ☐ Jail
- ☐ State Prison
- ☐ Federal Prison
- ☐ State Psychiatric Facility
- ☐ PSRB Board
- ☐ Justice Court
- ☐ None
- ☐ Other _____

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐