CLIENT ADMISSION FORM

Please fill out the following information for the person who will be receiving Mental Health or Addiction Services.
If you require assistance completing any forms, please let office staff know.

Today's Date:

Client Name (Last, First, Middle) _____

Preferred Name _____ Date of Birth _____

Last Name at Birth _____ SSN _____ County of Residence _____

Physical Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

How would you like to be notified of appointments? ❑ Email ❑ Text ❑ Email & Text ❑ Opt Out ❑ Phone ❑ Email & Phone ❑ Phone & Text

Are you deaf or do you have serious difficulty hearing? ❑ *No* ❑ *Yes* **If yes, what age did it begin?* _____

Are you blind or do you have serious difficulty seeing, even when wearing glasses? ❑ *No* ❑ *Yes* **If yes, what age did it begin?* _____

Preferred Language _____ **Do you need or want an interpreter?** ❑ *No* ❑ *Yes*

How well do you speak English?
❑ Very Well ❑ Not Well
❑ Well ❑ Not at all

If you need or want an interpreter, what type of interpreter is preferred?
❑ Spoken language interpreter
❑ American Sign Language Interpreter
❑ Contact sign language (PSE) interpreter
❑ Other: *Specify Type:*

Gender at Birth:
❑ Female
❑ Male

Gender Identity:
❑ Female
❑ Male ❑ Other

Pronoun(s) Used:
❑ She/Her
❑ They/Their/Them
❑ He/Him
❑ Other: _____

Marital Status:
❑ Never Married ❑ Divorced
❑ Married ❑ Widowed
❑ Separated

Household Support by Income:
_____# of Child Dependents (age 0-17)
_____# in Household (including yourself)

Veteran Status:
❑ Never in Military ❑ Veteran, Branch _____ ❑ Active Duty, Branch _____ ❑ Unknown/Refused

Race:
❑ Alaska Native
❑ American Indian
❑ Asian
❑ Black/African American
❑ Native Hawaiian/Pacific Islander
❑ White
❑ Other Single Race
❑ Two or More Unspecified Race

Ethnicity:
❑ Not of Hispanic/Latinx Origin
❑ Cuban
❑ Mexican
❑ Puerto Rican
❑ Unknown/Refused
❑ Hispanic/Latinx-specific Origin Not Specified
❑ Other Specific Hispanic/Latinx

Tribal Affiliation:
❑ Not Applicable
❑ Burns Paiute Tribe
❑ Confederated Tribes of Coos, Lower Umpqua & Siuslaw
❑ Confederated Tribes of Grand Ronde
❑ Confederated Tribes of Siletz
❑ Confederated Tribes of the Umatilla
❑ Confederated Tribes of Warm Springs
❑ Cow Creek Band of Umpqua Indians
❑ Coquille Indian Tribe
❑ Klamath Tribes
❑ Other: _____

Living Arrangement:
❑ Private Residence (home)
❑ Private Residence (relative)
❑ Private Residence (non-relative)
❑ Private Residence (other)
❑ Homeless/Transient
❑ Foster Home
❑ Jail
❑ Prison
❑ Supported Housing
❑ Oxford House
❑ Alcohol & Drug Free Housing
❑ Secure Residential
❑ Room and Board
❑ Residential Facility *Specify Type:* _____
❑ Other:

Legal Status ❑ None
❑ Parole
❑ Probation
❑ Incarcerated
❑ Aid & Assist
❑ DUII Diversion
❑ DUII Convicted
❑ Civil Commitment, *30 days*
❑ Civil Commitment, *90 days*
❑ Civil Commitment, *180 days*
❑ Involuntary Custody
❑ Guardianship (Court)
❑ Guardianship (Child Welfare)
❑ Pre-Booking Jail Diversion
❑ Post-Booking Jail Diversion
❑ Psychiatric Security Review Board
❑ Juvenile PSRB

Probation or Parole Officer Name & Phone:

For DUII Clients ONLY *Driver's License Number:* *Issuing State:*

Total Arrests: Lifetime _____

Total Arrests within last 30 days:

Total DUII Arrests: Lifetime: _____

Total DUII Arrests within last 30 days:

Monthly Gross Income ***(Before Taxes)***: $_____

Source of Income:

❑ Wages/Salary ❑ Public Assistance
❑ Disability/SSDI ❑ Retirement/Pension/SSI
❑ None ❑ Unknown ❑ Other: _____

Employment:

❑ Full Time ❑ Part Time ❑ Unemployed ❑ Student
❑ Homemaker ❑ Retired ❑ Disabled ❑ Not in Labor Force
❑ Other Reported Classification (e.g. volunteer)
❑ Sheltered/Non-competitive/Subsidized Employment (e.g. WITCO)

Employer Name: _____ Employer Phone: _____

Employer Address City State Zip

Who referred you to Lifeways?

Name of Referral Phone

Primary Care Provider City State Phone

Primary Care Provider Group (Clinic Name)

Do you currently have Mental Health Treatment services established? ❑ No ❑ Yes, Where? _____

Do you currently have Substance Abuse Treatment services established? ❑ No ❑ Yes, Where? _____

Dental Provider City State Phone

Emergency Contact Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Relationship to Client ❑ Father ❑ Mother ❑ Sibling ❑ Family (Other) ❑ Friend ❑ Significant Other ❑ Other: _____

If you are over the age of 18, do you have a legal guardian? ❑ Yes ❑ No
(***Note:*** *If yes, please provide legal documentation stating guardianship and/or legal notice.*)
If the client is 13 years of age or under, is the legal guardian present? ❑ Yes ❑ No

Guardian Name Guardian Phone Number

Financially Responsible: (Only fill out if different than client **OR** if client is a minor**)**

Name (Last, First) _____ Phone _____

Date of Birth _____ SSN _____

Mailing Address City State Zip

Please provide a copy of your insurance card(s).

Type of Insurance: ❑ Uninsured ❑ Medicaid ❑ Medicare ❑ Private Insurance ❑ Unknown

Primary Insurance Name _____ Phone _____

Name of Insured _____ Relationship to Client _____

Insurance ID# Insurance Group#

Secondary Insurance Name _____ Phone _____

Name of Insured _____ Relationship to Client _____

Insurance ID# Insurance Group#

Do you have a Declaration of Mental Health Treatment? ❑ No ❑ Yes, *if yes, is a copy available?* ❑ *No* ❑ *Yes*
(DMHT is a representative who can make mental health treatment decisions when the client is incapable of making decisions)
Do you have an Advanced Directive? ❑ No, *if no, would you like information on Advanced Directives?* ❑ *No* ❑ *Yes*
❑ Yes, *if yes, is a copy available?* ❑ *No* ❑ *Yes*

Are you interested in registering to vote? ❑ No ❑ Yes Are you interested in supported employment services? ❑ No ❑ Yes

Highest grade completed: _____ Are you or could you be pregnant? ❑ N/A ❑ No ❑ Yes, *Estimated Due Date:* _____

Do you use tobacco? ❑ No ❑ Yes Have you had your flu vaccine this year? ❑ No ❑ Yes

Substance use in the last 90 days? ❑ No ❑ Yes, type:

Other agencies that are providing services to you: (select all that apply)

❑ ADES
❑ Juvenile Department
❑ Oregon Youth Authority
❑ Community Corrections
❑ Public Health Department
❑ DHS Child Welfare
❑ DHS Self Sufficiency
❑ Seniors & People with Disability
❑ Vocational Rehabilitation
❑ None
❑ Other: _____

Release of Information for Payment

Initial _____ I authorize the release of any mental health or alcohol and drug treatment information necessary to process insurance claims. Furthermore, I authorize direct payment of health care benefits to Lifeways, Inc., for any service provided. I understand that I am ultimately responsible for all charges whether or not paid by my health insurance or any other payer source, including DHS if I make use of the sliding fee scale.

Acknowledgment of Receipt

Initial _____ Acknowledgment of Receipt of Lifeways' Client Handbook and Privacy Notice: By signing below, I acknowledge receipt of the Lifeways' Notice of Privacy Practices in my primary language.

Consent for Use and Disclosure of Protected Health Information

By signing below, I consent to the use and disclosure of health information about me in order that LIFEWAYS and its employees and contractors may provide treatment to me, obtain payment (for the treatment) from my third-party payers (e.g. the Oregon Medicaid program for HMO) and carry out their health care operations. I specifically authorize their use and disclosure of my health information about treatment of mental illness, HIV/AIDS test results, and alcohol and drug abuse treatment program services (if any) for such treatment, payment and health care operations purposes. I understand that this consent to use and disclosure information expires when I terminate treatment and that I may revoke this consent prior to that time, except to the extent to which LIFEWAYS has taken actions in reliance upon this consent. However, I also understand that no revocation of this consent is valid with respect to inspection of records necessary to validate expenditures on behalf of governmental entities.

X _____ _____

Client/Guardian Signature | Date

_____ _____

Client/Guardian Printed Name | Relationship to Client

Guarantor Signature

X _____ _____

Guarantor Signature | Date

_____ _____

Guarantor Printed Name | Relationship to Client

Lifeways' Consent for Treatment

Since Lifeways' services are designed to work with you in a partnership for wellness, the process we follow includes provisions for "Confidentiality" and certain specific client and provider "Rights and Responsibilities."

Confidentiality Statement

Lifeways staff will keep information about your case confidential, including the fact that you are receiving services, unless records are subpoenaed by a court of law, your counselor believes it is necessary to share information with other staff members, or law enforcement officials need to protect your safety or that of others. This would include periodic case reviews, medical emergencies, and violation of child abuse or neglect laws, danger to others or yourself, and release of information upon your request. At the time you apply to receive services from Lifeways, you will be given a copy of the Lifeways Notice of Privacy Practices, which fully describes your privacy rights.

Client Responsibilities

Lifeways' programs are designed to promote wellness by working to increase your functioning. We attempt to focus on solutions and resolve problems as quickly as possible. Longer-term counseling services may be indicated for more serious concerns.

- To choose or help Lifeways assign you to a mental health provider that you can work with and tell them all about your health;
- To treat Lifeways staff with respect;
- To get yearly check-ups, wellness visits and other services to prevent illness and keep you healthy;
- To get referral to a specialist before seeking care from a specialist unless self-referral to the specialist is allowed;
- To be on time for appointments and to call in advance if you expect to be late or unable to keep the appointment;
- To use urgent and emergency services when needed and to tell your Lifeways of any mental health emergency within 3 days;
- To ask questions about conditions, treatments and other issues related to your care that you don't understand;
- To use information to make informed decision about treatment before it is given;
- To help your provider come up with a treatment plan and treatment goals you will follow;
- To work together with your provider and follow plans, instructions for care and goals for recovery;
- To give accurate information for the clinical record;
- To help Lifeways get your clinical records from other providers which may include signing an authorization for release of information;
- To bring your medical ID cards to appointments, tell the receptionist that you have OHP and any other health insurance, and tell them if you were hurt in an accident;
- To pay for services not covered under your OHP benefit package if sign an 'Agreement to Pay' form before you get the services;
- To pay the monthly Medicare premium on time if required;
- To assist Lifeways, OHA, and DHS in pursing any third-party resources available and to reimburse Lifeways and/or DHS the amount of benefits it paid for an injury from any recovery received from that injury;
- To call OHP Central at 800-699-9075 when you move, have a new phone number, are pregnant or no longer pregnant, or when family members move in or out of the household;
- To report any other insurance you have, and changes to your insurance at www.ReportTPL.org; and
- To bring an issue, complaint, or grievance to the attention of Lifeways and/or OHA.
- Optum Idaho members additional responsibilities include:
  - ❖ You are responsible for providing Optum and its providers with information needed to provide quality care.
  - ❖ You are responsible for understanding your health problems to the best of your ability.
  - ❖ You are responsible for participating in the treatment and recovery plans to the best of your ability. You must let providers know if changes are needed.
- You are responsible for keeping, changing, or cancelling appointments instead of not showing up.

If you bring children for treatment, please do not leave them unattended in our waiting room. In order to be sure everyone is safe; Lifeways does not allow any weapons on its premises. Some people are allergic to animals and perfumed skin products.

Please help us protect their health by not bringing pets (except approved service animals) to appointments and by avoiding the use of perfumes and perfumed skin care products.

Please treat our staff with the same level of dignity and respect they provide to you. Treating people with dignity and respect includes avoidance of violent behaviors and refraining from making comments that could be harmful to others.

Lifeways' Responsibilities to You as a Client

Lifeways knows that you have a choice of service providers, and we are happy that you chose to work with us. Just as you have treatment responsibilities when you receive behavioral health services from Lifeways, we have treatment responsibilities when we provide services to you.

We know your time is valuable and will make every effort to see you when scheduled. When we cannot keep an appointment we've scheduled with you, we will make every effort to reschedule your appointment at least 24 hours in advance of the originally scheduled time.

Just as we ask that you participate in treatment in a way that is respectful and safe for service providers and any other Lifeways clients, we will also provide services to you in a respectful and safe way. Service providers will treat you with the dignity that you deserve.

If you do not understand forms that you are asked to fill out, please ask a Lifeways service provider to help you. We want to be sure you understand all about the services we offer to you, and know you have the right to question or ask for changes if something does not work for you.

Client Rights

As a person receiving services at Lifeways, you have the right to the following:

- Choose from available services and supports, those that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for the greatest degree of independence;
- Be treated with dignity and respect;
- Participate in the development of a written Service Plan, receive services consistent with that plan, and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written Service Plan;
- Have all services explained, including expected outcomes and possible risks;
- Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50;
- Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:
    - ❖ Under age 18 and lawfully married;
    - ❖ Age 16 or older and legally emancipated by the court; or
    - ❖ Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.
- Inspect their Service Record in accordance with ORS 179.505;
- Refuse participation in experimentation;
- Receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence;
- Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
- Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
- Have religious freedom;
- Be free from seclusion and restraint;
- Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;
- Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented;
- Have family and guardian involvement in service planning and delivery;
- Have an opportunity to make a declaration for mental health treatment, when legally an adult;
- File grievances, including appealing decisions resulting from the grievance;

- Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
- Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
- Exercise all rights described in this rule without any form of reprisal or punishment.

- To receive all health care services in a caring, non-judgmental way.
- Receive an explanation on how to exercise your rights. (Guardians also have this right)
- Information about rights and responsibility will be given in written form, upon request, in an alternative format or language appropriate to the individual's needs. (Guardians also have this right).
- To get healthcare services in a way that respects your culture. This includes getting you an interpreter if you do not speak English.
- The right to a second opinion.
- Additional Optum Idaho members specific rights:
    - ❖ To ask for and get information about Optum. This includes Optum services and network providers, and how to access both.
    - ❖ To not be bothered by either side if problems come up between Optum and its network providers.

Acknowledge of Integrated Health Record

_____(initial)*I understand Lifeways has an integrated health record which allows mental health staff access to information related to substance use or treatment or any other services I receive from Lifeways; I am therefore authorizing Lifeways staff members who need access to my protected health information to access the minimum necessary information in my record for such purposes. This is with the assurance that my substance abuse treatment information will not be reviewed in detail and the fact that I am receiving substance abuse treatment will not be disclosed to other programs outside of Lifeways without my explicit written authorization unless required by law.*

Consent for Telehealth and Telephone Services

_____(initial) *I hereby consent to using live videoconferencing and/or telephone services provided by Lifeways as part of its Tele-Health Program. I understand that these services may involve the communication of my health information, both orally and visually, to health care practitioners. Specifically, I understand that videoconferencing services include, but are not limited to, consultation, treatment, and transfer of health data using interactive recorded, stored, or archived from use of these live videoconferencing services. I also acknowledge that there are risks and consequences from use of telehealth services, including, but not limited to, the possibility, despite reasonable efforts on the part of Lifeways, that the transmisión of my health information could be disrupted or distorted by technical failures; and/or the transmisión of my health information could be intercepted or accessed by unauthorized persons.*

Consent for Treatment Services

_____(initial) *I understand and agree to the above information and terms of mental health and/or prevention and recovery services and consent to receiving services at Lifeways, Inc. I acknowledge that:*

- *I have been told about the possible risks and benefits of receiving and not receiving services and/or treatment.*
- *I've had the opportunity to ask questions and receive answers.*
- *I understand I have the right to refuse or withdrawal consent at any time without affecting my right to future care or treatment, nor risking the loss of withdrawal of any program benefits to which I would otherwise be entitled.*
- *I understand that I am responsible for canceling all appointments at least twenty-four (24) hours in advance. I understand that if I'm more than ten (10) minutes late to an appointment it will be cancelled, and I will need to reschedule.*

_____	_____	_____
Client Signature	(print name)	Date
_____	_____	_____
Parent or Guardian (signature)	Parent or Guardian (print name)	Date
_____	_____	_____
Lifeways Staff (signature)	Lifeways Staff (print name)	Date

Lifeways' Electronic Communication Consent

Lifeways offers the opportunity for service recipients to communicate with Lifeways through electronic messages over the Internet, World Wide Web, and other electronic networks. Examples of electronic messages might include, among others, messages or other information sent through email and text. Transmitting information by email or text messaging, however, has a number or risks that you should consider before deciding to use electronic messages to facilitate your treatment by Lifeways. These risks include, among others, the following:

- Messages can be circulated, forwarded, and stored in numerous paper and electronic files.
- Messages may be received by intended and unintended recipients.
- Message senders can easily misaddress messages.
- Electronic messages are easier to falsify than handwritten or signed documents.
- Backup copies of messages may exist even after the sender or recipient has deleted their copy.
- Employers and online service providers often have a right to archive and inspect messages transmitted through their systems.
- Messages are insecure and can be intercepted, altered, forwarded, or sent without authorization or detection.
- Messages can be used to introduce viruses into computer systems.
- Messages can be used as evidence in court.

If you choose to communicate with Lifeways using electronic messages, Lifeways asks that you acknowledge and consent to the following:

- I understand that electronic messages should not be used for emergencies or for communicating time sensitive information. In the event of a healthcare emergency I should contact 911 or go to the nearest Emergency Department. To communicate emergent or time sensitive information I should directly contact my local Lifeways office directly.
- I understand that electronic messages will be processed during routine business hours. In the event Lifeways does not respond, I understand that I should contact my local Lifeways office directly.
- I understand that due to situations outside the control of Lifeways, internet and email services may be interrupted or not work at any given time. Lifeways is not responsible for technical failures.
- I will not share, distribute, release or sell my healthcare provider's email address or texting phone number to anyone.
- I understand that email and texting are not a substitute for healthcare and evaluation. I must arrange for a scheduled appointment to assure appropriate care.
- I understand that I am to provide my full name and contact information in all emails, e.g. full name, address, phone number(s) on each email.
- I understand and accept that my provider may route my electronic messages to other staff members for informational purposes or for expediting a response. I authorize my provider to send and designate staff to receive and read this electronic communication.
- I understand that commonly used electronic messaging services are not secure and fall outside the security requirement set forth by the Health Insurance Portability and Accountability Act for the transmission of protected information. Therefore, I understand there is a risk that my health information may be obtained by others not affiliated with my provider. I authorize my provider to transmit my personal health information via electronic communications even though it may not be secure and private and may be subject to loss or exposure.
- I acknowledge and accept that either my healthcare provider or myself can terminate electronic communication services at any time. I understand that I am responsible for notifying Lifeways if I choose to discontinue electronic communication or if my email/ texting number has changed.
- I understand that standard text messaging rates my apply and Lifeways is not liable for those costs.

I acknowledge that I have read and fully understand this consent form and had the opportunity to ask questions. I understand the risks associated with electronic communication. I agree to hold Lifeways harmless for any injuries, losses, or damages arising from or in connection with electronic communication between Lifeways and myself. In addition, I agree to the instructions outlined above and will abide by any other instructions that Lifeways provides to me regarding electronic communication.

Safe Email Address:_____

Safe Text Messaging Number:_____

_____	_____	_____
Client Signature	(print name)	Date
_____	_____	_____
Parent or Guardian (signature)	Parent or Guardian (print name)	Date
_____	_____	_____
Lifeways Staff (signature)	Lifeways Staff (print name)	Date

Fee Agreement

Consent for Fee Agreement
When you choose services from Lifeways you will need to complete some forms at the time of service. On your first visit you should arrive early to complete registration forms. We will ask you for information about your insurance coverage and it will help if you bring your insurance card and information. We will ask you to sign forms to consent for treatment and to release information to your insurance company so they can pay for your treatment.

It is your responsibility to check with your insurance company or employer about whether or not you need prior approval or authorization before receiving services, or as soon as possible in emergency situations. You have the right to have disclosed to you, in writing, the amount and schedule of payment of any fees to be charged to you for services. You are financially responsible for your bill at the time you receive services. Please be ready to pay your portion at the time you receive services. Lifeways' staff can help you estimate total charges, and they can explain payment methods and plans. All account balances are due upon receipt of the bill. Lifeways will bill your insurance company based on the information you gave at the time of registration. It is your responsibility to notify Lifeways of any insurance coverage change you experience while receiving treatment.

You may apply for financial assistance from Lifeways either before or after you receive covered services. Eligibility is determined on an individual basis, taking into account such factors as family size, income, assets, and insurance status. If you have trouble with financial forms or the financial sliding scale, we will try to help you sort those issues out.

I understand and agree to pay the necessary fees and provide third party assignment at the time of service.

I understand that I may be charged a fee for appointments I miss without canceling twenty-four (24) hours in advance or for appointments for which I am more than ten (10) minutes late. (Oregon Health Plan clients with mental health and substance abuse treatment benefits are exempt from this fee).

I understand that I may be required by my insurance to make a co-payment and that this payment is due at the time services are rendered. I understand that I am ultimately responsible for any charges incurred on this account.

I agree to pay all charges not paid by insurance or any other payer sources. If legal proceedings are required to collect this account, I agree to pay all collection costs including reasonable attorney fees and court costs.
I have received a copy of Lifeways current fee schedule and agree to pay the fees as listed. I understand that some services may have minimum rate which is listed on the attached fee schedule.

I understand that I may be eligible for a discounted fee based on my gross household income that could significantly alter the cost of my services.

I also understand that I may be charged at the individual service rate for additional services such as consultation or case management as indicated in my treatment plan.

Client Signature	**Print Name**	**Date**
Parent or Guardian (signature)	**Parent or Guardian (print name)**	**Date**
Lifeways Staff (signature)	**Lifeways Staff (print name)**	**Date**

CONSENT AND ACKNOWLEDGEMENT FOR URINALYSIS TESTING

I, _____ hereby understand, that as part of my substance use treatment here at Lifeways, I am required to consent to and submit to random urinalysis (UA) testing to provide support in guiding my treatment goals. I consent to the requirement for random UA testing as outlined in this document.

1._____ UA testing will be conducted at the time of the initial assessment and throughout the treatment episode to help guide SUD program staff treatment with treatment recommendations and to determine appropriate level of care and services to support my overall recovery goals.
2._____ I understand that I will be required to call the UA hotline phone number Mon-Fri between 8am-10am to determine if I am required to provide a same-day UA (additional handout with instructions will be provided and explained at time of assessment.)
3._____ An initial test shall include, at a minimum, a sensitive, rapid, and inexpensive immunoassay screen to eliminate "true negative" specimens from further consideration.

1. 11 panel screen to include at a: Buprenorphine, Opiates, THC, Cocaine, MDMA, Oxycodone, Tricyclics, Amphetamines, Methadone, Barbiturates, Benzodiazepines
2. Definitive test: EtG/EtS, Fentanyl, Heroin Metabolite, Gabapentin, Naloxone, Xylazine, Kratom, Methylphenidate, Psylocibin
3. A confirmatory test is a second analytical procedure used to identify the presence of a specific drug or metabolite in a urine specimen. The confirmatory test shall be by a different analytical method from that of the initial test to ensure reliability and accuracy.
4. All urinalysis tests shall be performed by laboratories meeting the requirements of OAR 333- 024-0305 through 0365.

4._____ Failure to provide a UA will result in a “positive UA” and will be noted so in my client record with supported documentation.
5._____ Reporting of UA results and engagement of treatment will not be released without a proper Release of Information on file unless a court order mandates the release.
6._____ Multiple positive results may result in referral to a higher level of care or necessitate a change to your service plan and/or treatment status as deemed medically appropriate

_____ _____
Client Printed Name Date

_____ _____
Client Signature Date

LIFEWAYS

Authorization REVOKED on: _____

❑ Verbally by client ❑ In writing by client

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Clients' Name: _____ (Last Name) _____ (First Name) _____ (MI) Date of Birth: _____

The following person and/or entity is authorized to: ☒ **DISCLOSE and/or** ☒ **RECEIVE the specified information**

Name/Entity/Title	Malheur County Circuit Court
Address City State Zip	251 B Street W Box 3
Phone Number: 541-473-5193	Fax: 541-473-2213

This information is to be used for the following purpose(s) only (check all that apply):

❑ Continuity of Care/Coordination ❑ Educational ❑ Disability Claim

❑ Family Communication ☒ Attorney/Legal ❑ Compliance with Terms of Parole and Probation

Information to be released and/or disclosed by (must check at least one):

☒ Written & verbal exchange ❑ Verbal exchange only ❑ Written exchange only

Client/Guardian MUST initial next to information to be released and/or disclosed below:

____**Full-Service record, including all SUD services**

____ All Intellectual Developmental Disability (IDD) records or
____ Specific I/DD records: _____

____ All Educational (ED) records or
____ Specific ED records: _____

____ All Medical (MM) records or
____ Specific MM records: _____

____ All Psychiatric records (including labs) or
____ Specific Psych records: _____

____ All records to assist in conducting Case Management or
____ Specific CM records: _____

____ All Mental Health (MH) Records or
____ Specific MH Records: _____

____ All Substance Abuse (SUD) Records (including UA & swab results) or
____ Specific SUD records: _____

____ All information necessary to deal with an Emergency.
____ Information necessary to arrange transportation.
____ All Crisis Assessment and Crisis Follow-up Services
____ HIV/AIDS Information

___ **Other Information to be released/disclosed:** _____

Initials: ____ I understand Lifeways has an electronic health record which allows mental health staff access to information related to substance use or treatment or any other services I receive from Lifeways; I am therefore authorizing Lifeways staff members who need access to my protected health information to access the minimum necessary information in my record for such purposes. This is with the assurance that my substance abuse treatment information will not be reviewed in detail and the fact that I am receiving substance abuse treatment will not be disclosed to other programs outside of Lifeways without my explicit written authorization unless required by law.

Initials: ____ I understand I may revoke this authorization at any time by notifying Lifeways in writing or verbally, except to the extent that information has already been released in response to this authorization. I understand that there is a potential for information disclosed under the terms of this authorization to be redisclosed by the recipient and this redisclosure may no longer be protected by 45 C.F.R. 164, subpart E or applicable State law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition, _____. If I fail to specify an expiration date, this authorization will expire 90 days after discharge from Lifeways services/treatment.

Initials: ____ I have read and understand the terms of this Authorization to Disclose, Receive, and Use Protected Health Information. By my signature below, I voluntarily authorize disclosure, receipt, and use of my protected health information as indicated above. I understand that the information disclosed using this authorization may be subject to re-disclosure and will no longer be protected by federal law. Refusal to sign this authorization will not adversely affect a person's ability to receive services and Lifeways may not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this Release is generalized, I can request a list of entities to which my information has been disclosed.

Signature of ❑ Client or ❑ Legal Representative: **Date:**

Print Name of Guardian/Legal Representative (if applicable): **Describe authority to act for client:**

Clients 14 years or older are required to sign in order for this release of information to be valid.

**Information disclosed from any alcohol and drug abuse treatment records is protected by federal confidentiality rules (42 CFR part 2 and 45 CFR parts 160 and 164). Federal rules prohibit anyone from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of alcohol and drug treatment information released for criminal investigations or prosecution purposes.*

Authorization RECEIVED

Date: _____

Staff Name *(Printed)*: _____

Authorization REVOKED on: _____

❑ Verbally by client ❑ In writing by client

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Clients' Name: _____ (Last Name) _____ (First Name) _____ (MI) Date of Birth: _____

The following person and/or entity is authorized to: ☒ **DISCLOSE and/or** ☒ **RECEIVE the specified information**

Name/Entity/Title	Nepenthe Laboratory Services
Address City State Zip	1710 Willow Creek Circle, Eugene, OR 97402
Phone Number: 541-654-5039	Fax:

This information is to be used for the following purpose(s) only (check all that apply):

☒ Continuity of Care/Coordination
❑ Educational
❑ Disability Claim
❑ Family Communication
❑ Attorney/Legal
❑ Compliance with Terms of Parole and Probation

Information to be released and/or disclosed by (must check at least one):

☒ Written & verbal exchange ❑ Verbal exchange only ❑ Written exchange only

Client/Guardian MUST initial next to information to be released and/or disclosed below:

____**Full-Service record, including all SUD services**

____ All Intellectual Developmental Disability (IDD) records or
____ Specific I/DD records: _____

____ All Educational (ED) records or
____ Specific ED records: _____

____ All Medical (MM) records or
____ Specific MM records: _____

____ All Psychiatric records (including labs) or
____ Specific Psych records: _____

____ All records to assist in conducting Case Management or
____ Specific CM records: _____

____ All Mental Health (MH) Records or
____ Specific MH Records: _____

____ All Substance Abuse (SUD) Records (including UA & swab results) or
____ Specific SUD records: _____

____ All information necessary to deal with an Emergency.
____ Information necessary to arrange transportation.
____ All Crisis Assessment and Crisis Follow-up Services
____ HIV/AIDS Information

☒ **Other Information to be released/disclosed:**
Urinalysis and/or swab results

Initials: ____ I understand Lifeways has an electronic health record which allows mental health staff access to information related to substance use or treatment or any other services I receive from Lifeways; I am therefore authorizing Lifeways staff members who need access to my protected health information to access the minimum necessary information in my record for such purposes. This is with the assurance that my substance abuse treatment information will not be reviewed in detail and the fact that I am receiving substance abuse treatment will not be disclosed to other programs outside of Lifeways without my explicit written authorization unless required by law.

Initials: ____ I understand I may revoke this authorization at any time by notifying Lifeways in writing or verbally, except to the extent that information has already been released in response to this authorization. I understand that there is a potential for information disclosed under the terms of this authorization to be redisclosed by the recipient and this redisclosure may no longer be protected by 45 C.F.R. 164, subpart E or applicable State law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition, _____. If I fail to specify an expiration date, this authorization will expire 90 days after discharge from Lifeways services/treatment.

Initials: ____ I have read and understand the terms of this Authorization to Disclose, Receive, and Use Protected Health Information. By my signature below, I voluntarily authorize disclosure, receipt, and use of my protected health information as indicated above. I understand that the information disclosed using this authorization may be subject to re-disclosure and will no longer be protected by federal law. Refusal to sign this authorization will not adversely affect a person's ability to receive services and Lifeways may not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this Release is generalized, I can request a list of entities to which my information has been disclosed.

Signature of ❑ Client or ❑ Legal Representative: **Date:**

Print Name of Guardian/Legal Representative (if applicable): **Describe authority to act for client:**

Clients 14 years or older are required to sign in order for this release of information to be valid.

**Information disclosed from any alcohol and drug abuse treatment records is protected by federal confidentiality rules (42 CFR part 2 and 45 CFR parts 160 and 164). Federal rules prohibit anyone from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of alcohol and drug treatment information released for criminal investigations or prosecution purposes.*

Oregon Department of Human Services

Race, Ethnicity, Language, and Disability (READL)

Oregon Health Authority

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences.

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Please contact _____ at _____

Today's Date: _____ Medical record number (*if applicable*): _____

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth: _____

Race and Ethnicity

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

_____

2. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

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

Black and 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 Asian

Other categories
- ☐ Other *(please list)* _____
- ☐ Don't know
- ☐ Don't want to answer

3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?
- ☐ Yes. Please circle your primary racial or ethnic identity above.
- ☐ 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

(To be filled in by agency or clinic staff)

Agency or clinic: _____ **Agency staff or provider name or ID:** _____

Phone: _____ **Address:** _____

Language (*Interpreters are available at no charge*)

4a. What language or languages do you **use at home**? _____

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?

_____

4c. In what language do you want us to **write** to you? _____

5a. Do you need or want an **interpreter** for us to communicate with you?

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

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

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential. (**Please write in "don't know" if you don't know when you acquired this condition, or "don't want to answer" if you don't want to answer the question.*)		Yes	***If yes**, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking
7.	Are you **deaf** or do you have **serious difficulty hearing**?						
8.	Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?						
Please stop now if you/the person is under age 5							
9.	Do you have **serious difficulty walking or climbing stairs**?						
10.	Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?						
11.	Do you have **difficulty dressing or bathing**?						
12.	Do you have **serious difficulty learning how to do things most people your age can learn**?						
13.	Using your **usual (customary) language**, do you have **serious difficulty communicating** (*for example understanding or being understood by others*)?						
Please stop now if you/the person 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?						
15.	Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?						

LIFEWAYS

Authorization RECEIVED

Date: _____

Authorization REVOKED on: _____

❑ Verbally by client ❑ In writing by client

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Clients' Name: _____ (Last Name) _____ (First Name) _____ (MI) Date of Birth: _____

The following person and/or entity is authorized to: ❑ **DISCLOSE and/or** ❑ **RECEIVE the specified information**

Name/Entity/Title

Address City State Zip

Phone Number: | Fax:

This information is to be used for the following purpose(s) only (check all that apply):

❑ Continuity of Care/Coordination ❑ Educational ❑ Disability Claim

❑ Family Communication ❑ Attorney/Legal ❑ Compliance with Terms of Parole and Probation

Information to be released and/or disclosed by (must check at least one):

❑ Written & verbal exchange ❑ Verbal exchange only ❑ Written exchange only

Client/Guardian MUST initial next to information to be released and/or disclosed below:

____**Full-Service record, including all SUD services**

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____ Specific I/DD records: _____

____ All Educational (ED) records or
____ Specific ED records: _____

____ All Medical (MM) records or
____ Specific MM records: _____

____ All Psychiatric records (including labs) or
____ Specific Psych records: _____

____ All records to assist in conducting Case Management or
____ Specific CM records: _____

____ All Mental Health (MH) Records or
____ Specific MH Records: _____

____ All Substance Abuse (SUD) Records (including UA & swab results) or
____ Specific SUD records: _____

____ All information necessary to deal with an Emergency.
____ Information necessary to arrange transportation.
____ All Crisis Assessment and Crisis Follow-up Services
____ HIV/AIDS Information

___ **Other Information to be released/disclosed:** _____

Initials: ____ I understand Lifeways has an electronic health record which allows mental health staff access to information related to substance use or treatment or any other services I receive from Lifeways; I am therefore authorizing Lifeways staff members who need access to my protected health information to access the minimum necessary information in my record for such purposes. This is with the assurance that my substance abuse treatment information will not be reviewed in detail and the fact that I am receiving substance abuse treatment will not be disclosed to other programs outside of Lifeways without my explicit written authorization unless required by law.

Initials: ____ I understand I may revoke this authorization at any time by notifying Lifeways in writing or verbally, except to the extent that information has already been released in response to this authorization. I understand that there is a potential for information disclosed under the terms of this authorization to be redisclosed by the recipient and this redisclosure may no longer be protected by 45 C.F.R. 164, subpart E or applicable State law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition, _____. If I fail to specify an expiration date, this authorization will expire 90 days after discharge from Lifeways services/treatment.

Initials: ____ I have read and understand the terms of this Authorization to Disclose, Receive, and Use Protected Health Information. By my signature below, I voluntarily authorize disclosure, receipt, and use of my protected health information as indicated above. I understand that the information disclosed using this authorization may be subject to re-disclosure and will no longer be protected by federal law. Refusal to sign this authorization will not adversely affect a person's ability to receive services and Lifeways may not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this Release is generalized, I can request a list of entities to which my information has been disclosed.

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Print Name of Guardian/Legal Representative (if applicable): **Describe authority to act for client:**

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Notice of Privacy Practices of Lifeways, Inc.

Intent of Notice

This Notice describes:

- How health information about you may be used and disclosed
- Your rights with respect to your health information
- How to file a complaint concerning a violation of the privacy or security of your health information, or of your rights concerning your information

You have the right to a copy of this Notice (in paper or electronic form) and to discuss it with Lifeway's Compliance Director by phone 541.823.9004 or email complianceofficer@lifeways.org if you have any questions.

This Notice describes the privacy practices of Lifeways, Inc.. It applies to the health services you receive at Lifeways, Inc.. Lifeways, Inc. will be referred to herein as "we" or "us." We will share your health information among ourselves to carry out our treatment, payment, and healthcare operations.

Note: This is not a joint notice.

Our Privacy Obligations

We are required by law to maintain the privacy of your health information and to provide you with our Notice of our legal duties and privacy practices with respect to health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new Notice of Privacy Practices effective for all health information maintained by us. We are required to notify you in the event of a breach of your unsecured health information. A copy of any revised Notice of Privacy Practices or information pertaining to specific State law may be obtained by mailing a request to the contact person below.

Federal and State Law Notice

Federal and State laws require us to protect your health information and Federal law requires us to describe to you how we handle that information. Federal law (42 U.S.C. 290dd-2) does not override all State laws in the same area. If a use or disclosure is permitted by 42 CFR Part 2 but conflicts with State law, we will adhere to the more restrictive law. However, no State law can permit or require a use or disclosure prohibited by the 42 CFR Part 2 regulation.

See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations.

Uses and Disclosures of Your Health Information

We may use or disclose your health information for certain purposes without your written consent, including the following:

***Medical Emergencies*.** We may disclosure your health information to medical personnel when the disclosure is necessary to meet a bona fide medical emergency in which we are unable to obtain your written consent; or we are closed and unable to provide services or obtain your written consent during a temporary state of emergency as declared by a State or Federal authority.

***Scientific Research*.** We may use or disclose your health information to conduct scientific research if certain conditions are met.

***Audits and Evaluations*.** We may disclose your health information to conduct management audits, financial audits, and program evaluations to:

(1) A Federal, State, or Local governmental agency providing financial assistance to us;
(2) An individual or entity providing financial assistance to us, such as third-party payers who cover patients) or quality improvement organizations; or
(3) An entity with direct administrative control over us.

We may also disclose your health information to conduct a Medicare, Medicaid, or Children's Health Insurance Program (CHIP) audit or evaluation. This includes audits or evaluations necessary to meet the requirements for a Centers for Medicare and Medicaid Services (CMS)-regulated accountable care organization (ACO) or similar CMS-regulated organization.

***Public Health*.** We may disclose your health information for public health purposes when the disclosure is made to a public health authority and the health information disclosed has been de-identified in a manner that there is no reasonable basis to believe that the information can be used to identify you.

***Court Order*.** We may use and disclose your health information as authorized by a court order, provided certain regulatory requirements are met.

***Qualified Service Organizations*.** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times, it may be necessary for us to provide your health information to one or more of these outside individuals or organizations to assist us with services. In all cases, our contracts with these qualified service organizations require them to protect the privacy of your health information.

***Law Enforcement*.** We may disclose your health information to law enforcement agencies or officials but only as it relates to your commission of a crime on our property or against an employee, or a threat to commit such a crime, and such disclosure is limited to the circumstances of the incident.

***State or Local Authorities*.** We may disclose your health information to comply with State law reporting requirements of incidents of suspected child abuse and neglect to the appropriate State and Local Authorities.

***Health Care Operations*.** We may use or disclose your health information for certain activities necessary to operate our practice and ensure you receive quality care. For example, we may use the information to train or review the performance of our staff to make decisions affecting our organization.

***Health Information Exchange*.** We may take part in or make it possible for the electronic sharing of health information. The most common way we do this is through local or regional health information exchanges (HIEs). HIEs help doctors, hospitals, and other healthcare providers within a geographic area or community provide quality care to you. If you travel and need medical treatment, HIEs allow other doctors or hospitals to electronically contact us about you. All of this helps us manage your care when more than one doctor is involved, it helps us keep your health bills lower, for example, by avoiding repeating lab tests, and it helps us improve the overall quality of care provided to you and others. You may opt out of having your information shared through the HIE at any time either during registration or by submitting a written request to Lifeway's billing department. Opting out of the HIE sharing means your providers will need to obtain your records, as permitted or required by law and as described in this Notice, by other means, such as fax or mail.

Uses and Disclosures with Your Written Consent

Substance Use Disorder Counseling Notes. We must obtain your specific written consent for any use or disclosure of substance use disorder counseling notes. However, there are certain purposes for which we may disclose substance use disorder counseling notes without obtaining your written consent, including the following:

(1) To carry out treatment, payment, or healthcare operations (e.g., use by the creator of the substance use disorder counseling notes for treatment purposes);
(2) As required to the Secretary of the Department of Health and Human Services (HHS) to investigate or determine our compliance with the law;
(3) As permitted to determine the cause of a patient's death under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death;
(4) For oversight activities of the creator/originator of the substance use disorder counseling notes, as required by law;
(5) In response to a court order and when necessary to protect against an existing threat to life or of serious bodily injury, or in connection with an investigation or prosecution of an extremely serious crime; or in connection with a civil, criminal, administrative, or legislative proceeding in which you offer testimony or other evidence; and
(6) For purposes other than criminal investigation or prosecution in which a court order authorizes the use or disclosure of records or testimony relaying the information contained within them.

Treatment, Payment, and Healthcare Operations. We must obtain your written consent for the use and disclosure of your health information for treatment, payment, and healthcare operations. You may provide a single consent for all future uses and disclosures for these purposes, and we may use and disclose your health information for treatment, payment, and healthcare operations until you revoke your consent in writing.

General Designation. We may use and disclose your health information with your written consent to any person or category of persons identified or generally designated on the consent, except disclosures to central registries and in connection with criminal justice referrals which must meet additional requirements.

Prevent Multiple Enrollments. We may disclose your health information to a central registry or any withdrawal management or maintenance treatment program not more than 200 miles away to prevent multiple enrollments if certain conditions are applied.

Elements of the Criminal Justice System. We may disclose, with your written consent, information from your records to those persons(s) within the criminal justice system who made participation in our program a condition of the disposition of any criminal proceedings against you or of your parole or other release from custody if the disclosure is made only to those persons within the criminal justice system who require the information in connection with their duty to monitor your progress.

Prescription Drug Monitoring Programs. We may report any substance use disorder medication prescribed or dispensed by us to the applicable State prescription drug monitoring program as required by applicable State law with your written consent.

Civil, Criminal, Administrative, or Legislative Proceedings. Records, or testimony relaying the content within the records, will not be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless you provide us with specific written consent, or we receive a court order that is accompanied by a subpoena or other legal mandate compelling the disclosure. If we receive a court order, your health information will only be used or disclosed based on the court order after notice and an opportunity to be heard is provided to you (or the holder of the information), where required by 42 U.S.C. 290dd-2 and the 42 CFR Part 2 regulation.

Your Rights Regarding Your Health Information

Restrictions on Use and Disclosure of Your Health Information. You have the right to request restrictions on how we use or disclose your health information to carry out treatment, payment, or healthcare operations, even when you have signed a written consent for these uses and disclosures. We are not required to agree with your

restriction request but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict the disclosure of your health information to a health plan if the information pertains solely to a health care item or service for you, and you or someone other than the health plan on your behalf, has paid us in full.

If we agree to your request we will not use or disclose the health information in violation of the restriction, except if you require emergency treatment and the restricted health information is needed to provide emergency treatment, we may use the restricted health information, or we may disclose information that is derived from the record to a health care provider to provide treatment to you.

If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as appropriate. We will notify you if we remove a restriction imposed following this paragraph.

***Accounting of Disclosures of Your Health Information*.** You have the right to receive an accounting of disclosures made with written consent of your health information in the three (3) years prior to your request. You also have the right to receive an accounting of disclosures made by us of your health information for treatment, payment, and healthcare operations when the disclosure is made through the electronic health record (EHR). The request must be made in writing and signed by you or your personal representative. The first accounting in any 12-month period is free of charge; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

***List of Disclosures by Intermediary*.** If you have provided written consent to disclose your health information using a general designation, you have the right to request a list of entities that your information has been disclosed under the general designation. You must make your request in writing and the list of disclosures is limited to disclosures made within the past two (2) years.

***Fundraising Communications*.** We may use your health information to contact you in an effort to raise money for us. If you do not want us to contact you for fundraising efforts, you may elect not to receive fundraising communications by sending your request in writing to the contact person listed below.

***Right to Notice of a Breach*.** We take the confidentiality of your health information very seriously, and we are required by law to protect the privacy and security of your records through appropriate safeguards. You have the right to be notified of a breach of your unsecured health information, with a few limited exceptions. A breach is defined as the unauthorized acquisition, access, use, or disclosure of health information in a manner not permitted. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself unless there is a low probability that the privacy or security of your health information has been compromised.

***Right to a Paper Copy of this Notice*.** You have the right to obtain a paper copy of this Notice. You may obtain a copy of this Notice on our website, or you may also request a paper copy of this Notice at the location where you receive care.

Right to Change Terms of this Notice

We may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all records that we maintain, including any information created or received before issuing the new Notice. If we change this Notice, we will post the new Notice in common areas throughout our facility, and on our website.

Complaints

If you believe your privacy rights have been violated, you can file a complaint, in writing, with us. You may also file a complaint, in writing, with the Secretary of the Department of Health and Human Services (HHS) at the address below. There will be no retaliation for filing a complaint.

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.,
Washington, D.C. 20201
Toll-Free Call Center: 1-877-696-6775

Or go online to: https://www.hhs.gov/ocr/privacy/hipaa/complaints/

Contact

If you have questions, need further assistance regarding, or would like to submit a request pursuant to this Notice, you may contact our compliance director at 541.823.9004 for additional information:

Contact Person:	Lucas Hooker
Phone:	541.823.9004
Address:	702 Sunset Dr., Ontario, OR 97914
E-mail:	Complianceofficer@lifeways.org

Effective Date of This Notice

This Notice is effective as of May 1st, 2024.

LIFEWAYS FEES FOR CLINICAL SERVICES

MENTAL HEALTH SERVICES

Fees for Psychiatric Assessment MD, PMHNP or PA

Psychiatric Assessment- New Patient	$110-$325/hourly**
Psychiatric Assessment- Established Patient	$73-$215/hourly**
Psychiatric Medication Management	$73-215/hourly **
Psychiatric Nursing Services (one-to-one)	$150 / hour
Psychotherapy (in addition to Medication Management)	
16-37 minutes	$ 89.00
38-52 minutes	$135.00
53+ minutes	$202.00

Fees for Counseling Services

Mental Health Assessment	$180 / hour
Individual Therapy/Consultation	$180 / hour
Group Therapy	$45 / hour
Case Manager/Skills Training	$140 / hour
Group Skills Training/Activity Therapy	$35 / hour
Mentoring	$80 / hour

Note: Other fees for specialized Mental Health Services or for services provided outside the clinic setting may apply. For more information, ask your counselor during the treatment planning.

**** Depending on Level of care**

PREVENTION AND RECOVERY SERVICES

Fees for Treatment of Problem Use of Substances

Assessment	$300 / assessment
Counseling (one-to-one)	$160 / hour
Counseling (group)	$65 / hour

Note: Other fees for specialized Prevention and Recovery Services or for services provided outside the clinic setting may apply. For more information, ask your counselor during the treatment planning. Minimum fees may apply.

DISCUSSING FEES WITH YOUR COUNSELOR

If you anticipate possible problems paying for your treatment, discuss the issue with your counselor or ask at the reception desk to speak with a member of our customer service staff. Discounts based on family income are available for many services, and affordable payment plans can be arranged. We will work with you to make treatment possible.

Lifeways will attempt to verify insurance eligibility but it is not a guarantee of benefits or that insurance will cover the services you will be receiving. Many insurance carriers have contract exclusions that are not necessarily disclosed during the verification process.

Lifeways will bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balance, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. If your insurance carrier chooses to send the claim payments to you directly, you will be responsible to make those payments to Lifeways.

REVISED APRIL 2019

MOST PEOPLE ARE ELIGIBLE FOR REDUCED FEES BASED ON FAMILY INCOME. ASK ABOUT OUR SLIDING FEE SCALE.