



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

<b>Client Name (Last, First, Middle)</b> _____			
<b>Preferred Name</b> _____		<b>Date of Birth</b> _____	
<b>Last Name at Birth</b> _____	<b>SSN</b> _____	<b>County of Residence</b> _____	
<b>Physical Address</b> _____	<b>City</b> _____	<b>State</b> _____	<b>Zip</b> _____
<b>Mailing Address</b> _____	<b>City</b> _____	<b>State</b> _____	<b>Zip</b> _____
<b>Home Phone</b> _____	<b>Cell Phone</b> _____	<b>Email</b> _____	
How would you like to be notified of appointments?			
<input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Email & Text <input type="checkbox"/> Opt Out <input type="checkbox"/> Phone <input type="checkbox"/> Email & Phone <input type="checkbox"/> Phone & Text			

<b>Are you deaf or do you have serious difficulty hearing?</b>	<b>Are you blind or do you have serious difficulty seeing, even when wearing glasses?</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes *If yes, what age did it begin? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes *If yes, what age did it begin? _____

<b>Preferred Language</b> _____	<b>Do you need or want an interpreter?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>How well do you speak English?</b>	<b>If you need or want an interpreter, what type of interpreter is preferred?</b>
<input type="checkbox"/> Very Well <input type="checkbox"/> Not Well <input type="checkbox"/> Well <input type="checkbox"/> Not at all	<input type="checkbox"/> Spoken language interpreter <input type="checkbox"/> Contact sign language (PSE) interpreter <input type="checkbox"/> American Sign Language Interpreter <input type="checkbox"/> Other: <i>Specify Type:</i> _____

<b>Gender at Birth:</b>	<b>Pronoun(s) Used:</b>	<b>Marital Status:</b>	<b>Household Support by Income:</b>
<input type="checkbox"/> Female <input type="checkbox"/> Male <b>Gender Identity:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	<input type="checkbox"/> She/Her <input type="checkbox"/> They/Their/Them <input type="checkbox"/> He/Him <input type="checkbox"/> Other: _____	<input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	_____ # of Child Dependents (age 0-17) _____ # in Household (including yourself)

**Veteran Status:**  Never in Military     Veteran, Branch \_\_\_\_\_     Active Duty, Branch \_\_\_\_\_     Unknown/Refused

<b>Race:</b>	<b>Ethnicity:</b>
<input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other Single Race <input type="checkbox"/> Black/African American <input type="checkbox"/> Two or More Unspecified Race	<input type="checkbox"/> Not of Hispanic/Latinx Origin <input type="checkbox"/> Unknown/Refused <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic/Latinx-specific <input type="checkbox"/> Mexican <input type="checkbox"/> Origin Not Specified <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other Specific Hispanic/Latinx

**Tribal Affiliation:**

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

**Living Arrangement:**

<input type="checkbox"/> Private Residence (home)	<input type="checkbox"/> Homeless/Transient	<input type="checkbox"/> Supported Housing	<input type="checkbox"/> Room and Board
<input type="checkbox"/> Private Residence (relative)	<input type="checkbox"/> Foster Home	<input type="checkbox"/> Oxford House	<input type="checkbox"/> Residential Facility
<input type="checkbox"/> Private Residence (non-relative)	<input type="checkbox"/> Jail	<input type="checkbox"/> Alcohol & Drug Free Housing	<i>Specify Type:</i> _____
<input type="checkbox"/> Private Residence (other)	<input type="checkbox"/> Prison	<input type="checkbox"/> Secure Residential	<input type="checkbox"/> Other:

**Legal Status**  None

<input type="checkbox"/> Parole	<input type="checkbox"/> DUII Diversion	<input type="checkbox"/> Civil Commitment, 180 days	<input type="checkbox"/> Pre-Booking Jail Diversion
<input type="checkbox"/> Probation	<input type="checkbox"/> DUII Convicted	<input type="checkbox"/> Involuntary Custody	<input type="checkbox"/> Post-Booking Jail Diversion
<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Civil Commitment, 30 days	<input type="checkbox"/> Guardianship (Court)	<input type="checkbox"/> Psychiatric Security Review Board
<input type="checkbox"/> Aid & Assist	<input type="checkbox"/> Civil Commitment, 90 days	<input type="checkbox"/> Guardianship (Child Welfare)	<input type="checkbox"/> 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)

<input type="checkbox"/> ADES	<input type="checkbox"/> Public Health Department	<input type="checkbox"/> Vocational Rehabilitation
<input type="checkbox"/> Juvenile Department	<input type="checkbox"/> DHS Child Welfare	<input type="checkbox"/> None
<input type="checkbox"/> Oregon Youth Authority	<input type="checkbox"/> DHS Self Sufficiency	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Community Corrections	<input type="checkbox"/> Seniors & People with Disability	

**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 pursuing 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](http://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 transmission of my health information could be disrupted or distorted by technical failures; and/or the transmission 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 of 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 may 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



# LIFEWAYS

## 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**





Authorization RECEIVED

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

Authorization REVOKED on: \_\_\_\_\_

Verbally by client    In writing by client

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)**

**Clients' Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name First Name MI

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

\_\_\_\_ All Intellectual Developmental Disability (IDD) records or \_\_\_\_\_ All Mental Health (MH) Records or  
 \_\_\_\_ Specific I/DD records: \_\_\_\_\_ Specific MH Records: \_\_\_\_\_

\_\_\_\_ All Educational (ED) records or \_\_\_\_\_ All Substance Abuse (SUD) Records (including UA & swab results) or  
 \_\_\_\_ Specific ED records: \_\_\_\_\_ Specific SUD records: \_\_\_\_\_

\_\_\_\_ All Medical (MM) records or \_\_\_\_\_ All information necessary to deal with an Emergency.  
 \_\_\_\_ Specific MM records: \_\_\_\_\_ Information necessary to arrange transportation.  
 \_\_\_\_ All Psychiatric records (including labs) or \_\_\_\_\_ All Crisis Assessment and Crisis Follow-up Services  
 \_\_\_\_ Specific Psych records: \_\_\_\_\_ HIV/AIDS Information

\_\_\_\_ **Other Information to be released/disclosed:**  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_ All records to assist in conducting Case Management or  
 \_\_\_\_ Specific CM records: \_\_\_\_\_

**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.*





## Acceptable Items upon arrival:

- Feminine Hygiene Products
- Toothbrush, paste, & denture necessities (1 of each)
- Comb, Brush, & Hair Accessories
- Alcohol Free Mouth Wash (1)
- Hair Products: 1 of each product and a max of 3 products.
  - LRC will provide shampoo, conditioner, & body wash
- Lotion, Cologne, & Perfume (No heavily scented items, aerosol cans, or alcohol as an ingredient.) (1 each)
- Razors, Clippers, Tweezers, & Nail Polish (Items will be stored away by staff. Available on a check in/out basis.)
- Deodorant & Shaving Cream (No aerosol cans) (1 each)
- Make-Up Items (Must be in original packaging and all must fit in a 5x5 bag.)
- Tobacco Products: Vapes, Chewing Tobacco, & Cigarettes

**ALL ITEMS ABOVE MUST BE IN ORIGINAL SEALED PACKAGING!**

- Hair Dryer, Straightener, & Curling Iron (1 of each, max of 2)
- Pens, Pencils, & Highlighters (One pencil pouch max)
- Book (Max of 2)

**PLEASE BRING A 30-DAY SUPPLY OF ALL MEDICATION.**

**We will help facilitate refills at the client's cost.**

## Acceptable Clothing:

Clients are assigned a small dresser of 3 drawers to store all their belongings. All belongings must fit in the provided space. All items that do not fit will be sent home at the client's cost.

- 3 Pairs of Foot Covering
- Coat, Jacket, & Sweater
- 7 Pants or Shorts
- 7 Shirts
- 7 Undergarments
- 2 Bras, 1 Sports Bra
- 2 Baseball Caps or Hats  
(Appropriate for Residential Environment)
- 7 Pairs of Socks
- 2 Pairs of Pajamas



### **Non-Acceptable Items:**

- Bandanas
- Hair Dye
- Sleeveless Shirts or Tank Tops
- Offensive Language or Graphics
- Bottles or Canned Drinks of Any Kind
- Personal Pillows, Blankets, Stuffed Animals, or Towels (LRC will Provide Linens.)
- Short, Sheer, or Revealing Clothing
- Glass or Aerosol Items of Any Kind
- Electronic Devices (Including, but not limited to Kindles, iPads, Laptops, Smartwatches, ETC.)

### **NO WEAPONS OF ANY KIND**

Needs of non-acceptable items will be individually determined.

Any unacceptable items will not be allowed or accepted during intake. Our desire is to provide an uninterrupted recovery environment for all clients. We have a zero-tolerance policy regarding what NOT to bring or wear into our residential community and ask that you respect everyone's space and recovery environment.





# Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## Intent of Notice

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.

## Our Privacy Obligations

We are required by law to maintain the privacy of your protected health information and to provide you with our Notice of our legal duties and privacy practices with respect to protected 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 protected health information maintained by us. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act (“HIPAA”). 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 addressed below.

## Federal and State Law Notice

Federal and State laws require we protect your medical information and Federal law requires we describe to you how we handle that information. When Federal and State privacy laws differ, and the State law is more protective of your information or provides you with greater access to your information, then State law will override Federal law.

## Uses and Disclosures of Your Protected Health Information

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

***Treatment.*** We may use your information to provide you with medical treatment or services. We may disclose your medical information to others who are involved in taking care of you. We may share your medical information with another healthcare provider to deliver, coordinate, or manage your healthcare.

***Payment.*** We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

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

***Business Associates.*** 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 protected health information to one or more of these outside persons or organizations to assist us with our healthcare operations. In all cases, our contracts with these business associates require them to protect the privacy of your protected health information.

**Health Information Exchange.** We may take part in or make possible the electronic sharing of healthcare 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 PHI shared through the HIE at any time either during registration or by submitting a written request to Lifeways' 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.

**Other Uses or Disclosures.** We may also use or disclose your information for certain purposes allowed by 45 CFR 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health and safety of others.
- As required by State or Federal law such as reporting abuse, neglect, or certain other events.
- As allowed by workers' compensation laws for use in workers' compensation proceedings.
- For certain public health activities such as required reporting of immunizations, disease, injury, birth, and death, or in connection with public health investigations.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant, or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as military services or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim, or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

## Disclosures We May Make Unless You Object

Unless you instruct otherwise, we may disclose your information as described below:

**Individuals Involved in Your Care or Payment for Your Care.** We may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care or in the payment of your care to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts for that entity to locate a family member or other persons who may be involved in some aspects of caring for you.

**Appointments and Services.** We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders not to be left on your voicemail or sent to a particular address, we will accommodate reasonable requests. With such requests, you must provide an appropriate alternative address or method of contact. You also have the right to request that we do not send you any future marketing materials and we will use our best efforts to honor such requests. You must make such requests in writing, including your name and address, and send such writings to the contact person listed below.

**Fundraising.** We may use your information to contact you in an effort to raise money for us. We may also disclose information to a related foundation so that the foundation may contact you for similar purposes. If you

do not want us or the foundation to contact you for fundraising efforts, you must send such a request in writing to the contact person listed below.

**Facility Directory.** If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclose your religious affiliation to the clergy.

**School Immunization Requests.** We may share your protected health information for purposes of school immunization requests if the school is required by law to have documentation of such immunizations(s) for enrollment.

**As Required by Law.** We may use and share your protected health information when required to do so by any other law not already referred to above.

## Uses and Disclosures with Your Written Authorization

**Psychotherapy Notes.** We must obtain your specific written authorization before disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment, or health care operations (e.g., use for the purposes of your treatment), (2) to the Secretary of the Department of Health and Human Services (HHS) to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by State law, or (6) to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

**Genetic Information.** We must obtain your specific written authorization before using or disclosing your genetic information for treatment, payment, or healthcare operations. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

**Sensitive Medical Information.** We may obtain written permission from you, when required by State and Federal laws, to use or share sensitive medical information, such as mental health or substance abuse information.

**Marketing.** We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of face-to-face communication with you. For other marketing activities, we will obtain your authorization.

**Sale of Protected Health Information.** We must obtain your authorization before receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities;
- Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger, or consolidation of all or part of our business and for related due diligence;
- Payment, we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of the business associate) and the only remuneration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures;
- Disclosures required by law;
- Disclosures of your health information for any other purposes by and in accordance with the HIPAA Privacy Rule, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law, or
- Any other exceptions allowed by the Department of Health and Human Services (HHS).

## Your Rights Regarding Your Protected Health Information

**Access to Your Protected Health Information.** You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy (at a limited cost or, in some cases, free of charge) of such health information in a

reasonable electronic format, if readily producible. Access requests must be made in writing and signed by you or your Personal/Legal Representative.

We may deny your request to inspect or receive copies in limited circumstances. If your request is denied, you may ask that the denial be reviewed. Another licensed healthcare professional whom we choose will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

***Amendments to Your Protected Health Information.*** You have the right to request, in writing, that the protected health information we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests must be in writing, signed by you or your Personal/Legal Representative, and it must state the reason(s) for the amendment/correction request. If we accept your request, we will tell you we agree and we will amend your records. We cannot change what is in the record. With your assistance, we will notify others who have the incorrect or incomplete medical information. If an amendment or correction is made, we may notify others who work with us if we believe such notification is necessary.

We may deny your request if the information: (1) was not created by us unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for us; (3) is not part of the information that you would be permitted to inspect or receive copies of; or (4) is accurate and complete.

If your request to amend your record is denied, you will have the right to have certain information related to the requested amendment included in your records. These rights will be explained to you in the written denial notice.

***Accounting for Disclosures of Your Protected Health Information.*** You have the right to receive an accounting of certain disclosures made by us of your protected health information in the six (6) years prior to your request. This list will not include every disclosure made, including those disclosures made for treatment, payment, and health care operations, or those disclosures made directly to you or with your consent. Requests must be made in writing and signed by you or your Personal/Legal Representative. The first accounting in any 12-month period is free; 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.

***Restrictions on Use and Disclosure of Your Protected Health Information.*** You have the right to request restrictions on how we use or disclose your health information to treat your condition and collect payment for your treatment or for our healthcare operations. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is to carry out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for you, or someone other than the health plan on your behalf, has paid us in full.

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 in accordance with this paragraph.

***Right to Request Confidential Communication of Your Protected Health Information.*** You may request that we communicate with you about medical matters in an alternative way or at an alternative location (for example, you may wish to be contacted at work rather than at home). Your request should be directed to the area that would handle the communication. You do not need to provide a reason for your request. Reasonable requests will be accommodated.

***Right to Notice of a Breach.*** We take the confidentiality of your information very seriously, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. You have the right to be notified of a breach of your unsecured protected health information, with a few limited exceptions. A breach is defined as the unauthorized acquisition, access, use, or disclosure of protected 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 protected 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 protected health information 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 our Privacy Officer. You may also file a complaint, in writing, with the Secretary of the Department of Health and Human Services at the below address. 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 for additional information:

Contact Person: Lucas Hooker  
Phone: 541.823.9004  
Address: 702 Sunset Dr., Ontario, OR 97914  
E-mail: [complianceofficer@lifeways.org](mailto:complianceofficer@lifeways.org)

## Effective Date of This Notice

This Notice is effective as of May 1<sup>st</sup>, 2024.

