PLEASE NOTE:

THIS PACKET MUST BE COMPLETED AT LEAST ***48 HOURS*** PRIOR TO YOUR APPOINTMENT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE RESOURCE CENTER. IF WE DO NOT RECEIVE THIS PACKET ACCORDING TO THESE GUIDELINES, IT MAY BE NECESSARY TO RESCHEDULE YOUR APPOINTMENT.

IMPORTANT: YOUR FIRST APPOINTMENT WILL TAKE APPROXIMATELY ***90 MINUTES*** TO COMPLETE. PLEASE ALLOW FOR A MINIMUM OF 1 ½ HOURS FOR THIS APPOINTMENT.

This packet contains required paperwork which is essential to beginning treatment. Please complete all documents as completely as possible, ***including signatures.*** If you are not able to provide any portion of the information requested, or if you have questions about how to complete any of the paperwork included in this packet, please call the Resource Center at: 541-997-5410 (Siuslaw) or 541-268-6824 (Mapleton), and we will do our best to assist you.

THANK YOU. WE LOOK FORWARD TO WORKING WITH YOU!

SIUSLAW STUDENT RESOURCE CENTER
2221 Oak. St. Florence, Oregon.
Hours: Monday, Wednesday, Friday 8:30-5:00.

MAPLETON COMMUNITY RESOURCE CENTER

10868 E. Mapleton Rd. Mapleton, Oregon.

Hours: Tuesday & Thursday 8:30-5:00.

Appointment Acknowledgement and Release

Having our resource centers on school grounds gives us the unique opportunity of easier access for the children and teens we serve. Each resource center is within walking distance of all schools in their respective district. With that in mind, it is still school policy for the parent/guardian to sign their student in/out of school for appointments. In order to reduce barriers to care and make this process quicker and more efficient, we have formed an agreement with the schools to allow for students to attend appointments at their respective resource center *without* having to be signed in/out by their parent/guardian for every appointment. Instead, the parent/guardian can sign a one-time form that gives permission for their student to attend *all* future appointments at the resource center.

Student's Name: ____________________________ Student's School: ____________________________

By signing this form, you are acknowledging and giving permission for your student to attend all future appointments at one of our resource centers (Siuslaw Student Resource Center or Mapleton Community Resource Center).

Print Name:__________________________ Signature:__________________________ Date:__________

****MAPLETON ELEMENTARY STUDENTS ONLY**

I understand that if my child is in the Elementary school it is the parent/guardian's responsibility to transport my child back and forth for appointments. If I am unable to transport my child, I must call the Mapleton Elementary School office the morning of the scheduled appointment to inform them of this (541-268-4471).

Students in grades 3-6 may walk from the elementary school to the resource center and back on their own with parent/guardian permission. (please check one box)

☐ My child is in grade 3-6 and has permission to walk to and from the Mapleton Community Resource Center on their own.

☐ My child is in grade 3-6 and DOES NOT have permission to walk to and from the Mapleton Community Resource Center on their own, I will transport them to and from appointments.

Print Name:__________________________ Signature:__________________________ Date:__________

1. Child Information

Date: ____________________

Child's Full Name: ________________________ Nickname: ________________

Birth Date: ____________ Born in: City: __________________ State: ___________

		Relationship	Phone #
Person completing form:	____________	____________	____________
Person with legal custody:	____________	____________	____________
Child living with:	____________	____________	____________

Address: ____
(Street) *(City, State)* *(Zip)*

If child is not living with natural parents, give length of separation and the reason for separation: ____________

2. Family Composition – Please list all adults and children in the home where the child is living:

Is this home (check one) ❑ Natural ❑ Foster ❑ Other ______________________

Name	**Birth Date**	**Sex**	**Relationship**	**Occupation**

Date of Marriage: ________________________

List natural family members not living in the home:

Name	**Birth Date**	**Sex**	**Relationship**	**Occupation**

Is there is a file on this child at Services to Children and Family? ❑ No ❑ Yes

Name of Children's Services Division worker: ______________________

3. **Does your child have any of the following problems?** Check all that apply:

- ❑ Nightmares
- ❑ Fighting
- ❑ Stealing
- ❑ Disruptive behavior
- ❑ Fire setting
- ❑ Hot temper
- ❑ Swearing
- ❑ Deliberately hurts self
- ❑ Lying
- ❑ Disobeys
- ❑ Problems in school
- ❑ Excessive fears
- ❑ Withdrawn
- ❑ Depressed
- ❑ Difficulty paying attention
- ❑ Hyperactivity
- ❑ Anxiety
- ❑ Difficulty with concentration
- ❑ Sleep difficulty
- ❑ Other ____________

When did the child start having problems? ______________________

Please list other problems which concern you ______________________

Patient Identification

4. Social History

	Always	Usually	Sometimes	Rarely	Never
Is easily managed	❑	❑	❑	❑	❑
Gets along with mother	❑	❑	❑	❑	❑
Gets along with father	❑	❑	❑	❑	❑
Gets along with brother/sister	❑	❑	❑	❑	❑
Gets along with other children	❑	❑	❑	❑	❑
Likes himself/herself	❑	❑	❑	❑	❑
Has friends in neighborhood	❑	❑	❑	❑	❑

Expresses anger by ____________________

Whom does he/she mind best? ____________________

What type of discipline works best? ____________________

How often is discipline used? ____________________

Any nervous habits? ____________________

Has any event occurred during the child's life which has had a profound effect on him/her? (Examples: a death, physical, a move, a divorce, loss of job, remarriage, etc.). If so, please explain: ____________________

____

5. Interests, Abilities, Responsibilities:

My child enjoys doing the following: ____________________

With friends: ____________________

With family: ____________________

My child enjoys doing the following things well: ____________________

My child does the following jobs at home: ____________________

Once a week: ____________________

Once or more a day: ____________________

Other: ____________________

Reaction to change in routine: ____________________

Attention span: ____________________

What does your child do best at school? ____________________

What does your child do worst at school? ____________________

How do you reward your child? ____________________

6. Previous Evaluations (for example; psychological evaluation, academic evaluation, evaluation of handicap): ____________________

WHEN ____________ WHERE ____________ BY WHOM ____________

What were you told? ____________________

Patient Identification

7. Please list all schools attended including preschool or group daycare.

SCHOOL	GRADE	CHILD'S AGE

8. Any other comments you wish to make?

____
____
____
____

MEDICAL INFORMATION FORM

1. Birth and Development

PREGNANCY (while carrying the child)

YES	NO	
❑	❑	Adopted
❑	❑	Complications
❑	❑	High temperature
❑	❑	Communicable disease
❑	❑	On medication
❑	❑	Carried all pregnancies to term

BIRTH

YES	NO	
❑	❑	Difficult labor
❑	❑	Difficult delivery
❑	❑	Baby premature
❑	❑	Baby late
❑	❑	Discolored at delivery
❑	❑	Difficulty breathing
❑	❑	Difficulty responding to light
❑	❑	Difficulty responding to sound
❑	❑	Blood incompatibility

2. Medical History

YES	NO	
❑	❑	Birth defects
❑	❑	Head/back injury
❑	❑	Asthma
❑	❑	Fainting
❑	❑	Unconscious
❑	❑	High temperature
❑	❑	Seizure
❑	❑	Vision normal
❑	❑	Hearing normal
❑	❑	Wets at night
❑	❑	Wets during the day

YES	NO	
❑	❑	Frequent colds
❑	❑	Ear infections
❑	❑	Stomach complaints
❑	❑	Chicken pox
❑	❑	Strep/Staph infection
❑	❑	Pneumonia
❑	❑	Diabetes
❑	❑	Soiled pants
❑	❑	Sleeps well
❑	❑	Eats well

List surgeries or hospitalizations	Date	Age of child

List current medication(s)	Dose

Who is your child's doctor now: ______________________________ Phone number: ______________________

Who is your child's dentist now: ______________________________ Phone number: ______________________

3. List allergies and describe treatment: ____

____

4. Do any other family members have medical problems? Please describe: ____________________________

____

5. Development (Please report age in months or years)

First word ____ First crawled ______________________________

First sentence _____________________________________ First walked _______________________________

First sat unassisted _______________________________ Toilet trained ______________________________

Generally, was development early, later or average? ____

6. Are there special medical precautions?

____

____

____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________ **DATE:** ____________

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

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A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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A2662B 10-04-2005

PeaceHealth

Authorization to Use and Disclose Health Information

Patient

Patient Name: ______________________ Birth Date: __________ Ph. #: __________

SSN: __________ Address: ______________________

From / To

I authorize the use and/or disclosure of the health information described below for the above-named patient by the following entities: ***(Complete addresses required in order to process request)***

Information is to be released FROM:	Information is to be disclosed TO:
______________________	Peace Health Medical Group
______________________	Florence, OR 97439
______________________	PH 541-997-5410 FAX 541-997-4336

Please specify the hospital, clinic, or practice holding the records.

____

____

Purpose

For the purpose(s) of:

- ❑ At the request of the patient or legal/personal representative
- ❑ Other purposes (specify each purpose): ______________________

Info to be Disclosed

Description of nature of information to be used and/or disclosed: (initial all that apply)

		Specially Protected Information:
____ Discharge summaries	____ Pathology reports	____ Mental health treatment records
____ History & Physical exams	____ Radiology/imaging reports	____ Drug/Alcohol abuse diagnosis, treatment, and referral records
____ Consultations	____ Laboratory reports	____ Information re: HIV/AIDS/Sexually transmitted diseases
____ Operative reports	____ EKG reports	____ Information re: Genetic testing (Oregon)
____ Physician progress notes	____ Emergency Dept. record	______________________
____ Nursing notes	____ Medication records	
____ Clinician office notes	____ Billing statements	

____ Other information (specify): ______________________ ____ Records for the following dates or treatment: ______________________

____ All health records from the above-named entity (Excludes above Specially Protected information unless indicated by initials)

Notices

1. I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, Sexually Transmitted Diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment, or referral information, Federal law and regulation including 42 CFR Part 2 and 445 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information.
2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.
3. I may revoke this authorization at any time by notifying the Health Information Management/Medical Records Department of the above-named entity on its designated form. However, any such revocation will not apply to any activity undertaken based on this authorization. PeaceHealth's Joint Notice of Privacy Practices also describes how to revoke this authorization.
4. I received a copy of this authorization. I may inspect or request copies of information disclosed by this authorization.

Dates

Unless revoked, this authorization is valid for 90 days from the signature date below or for the following time period.

Beginning date: ______________ Ending (expiration) date: ______________

(In Washington state, expiration date can be no later than 1 year after this authorization is signed if disclosure is to employer or financial institution.)

Signature

SIGNATURE: I have read this authorization, and I understand it.

______________________ ______________ __________

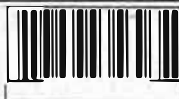
Signature of Patient or personal representative   Relationship to patient   Date

*If the patient's personal representative, you may be required to provide appropriate documentation to demonstrate authority to act on behalf of the patient (Examples of documentation include Power of Attorney, Death Certificate, Court order)

For PeaceHealth Use Only

Date Received: __________ MRUN # __________ Acct # __________ ❑ Identity and authority verified

❑ Fees explained if needed ❑ Records sent by __________ Date/Time: __________

Please don't write in box: 

Release of Information Authorization SYS1020 (09/27/18)

White Copy: Med. Record. Yellow Copy: Patient

PEACEHEALTH COUNSELING SERVICES CONFIDENTIALITY POLICY

It is against the policy of PeaceHealth Counseling Services to speak about anything seen or heard at the office to others outside about the office business or client activities. This includes talking to anyone, including: spouse, parents or other family members, children, friends, business associates, church members, club members or etc.

What goes on at PeaceHealth Counseling Services is business and confidential. This is to protect the confidentiality of all current and future clients.

I have read the above policy and understand it's meaning. I pledge to respect the confidentiality of all staff members and especially the other clients.

WRITTEN CONFIDENTIALITY

I understand that PeaceHealth Counseling Services maintains a written record for each person. I also understand that my right to confidential handling of this information will be protected.

PeaceHealth Counseling Services will not collect from other sources without any knowledge and written consent. No information about me will be shared without my written consent, which specifies exactly to whom, the nature of the information and for what purpose the information will be released unless required by law. In a situation where the law requires release of information; i.e., a legal subpoena, PeaceHealth Counseling Services will notify me immediately.

Records are subject to routine audit by the County and/or State Mental Division and the vocational Rehabilitation Division to insure that quality of service is maintained by PeaceHealth Counseling Services.

No photographs, observations or recordings either audio or visual will be made without my prior written consent.

PEACE HARBOR EXCLUSION

I also understand that the sharing of information with my PCP or other clinical staff of PeaceHealth Siuslaw Region is not subject to this clause, as PeaceHealth Counseling Services personnel work closely with these agencies/individuals in order to be able to aid in the proper diagnosis and prescribing of medication of clients enrolled at PeaceHealth Counseling Services.

______________________________ ______________________

Client Signature Date/Time

For staff use only: Interpreter service and/or special accommodations provided?
- ❑ ***YES***
- ❑ ***Not Needed***

PeaceHealth
Medical Group

Behavioral Health Services

Patient/Client Provider Responsibility Disclaimer Form

As a client of PeaceHealth Medical Group Behavioral Health Services, you have rights as well as responsibilities. Providers and staff of the department want to make sure your rights are respected and that you are informed about the following:

A clinical record, which is the property of PeaceHealth Medical Group, is maintained documenting all services provided to you by PHMG Behavioral Health providers. This record also contains information that may be received from other sources, including progress notes from physicians and other records that may be obtained with your written consent.

Information contained in the clinical record is confidential and will be released only to persons or agencies outside of PeaceHealth with your written consent (or your parents/guardian if you are a minor). Before giving your written consent to release information, please be sure that you understand what specific information is being requested, the release of information is needed and necessary, and by providing this information it will be beneficial to you.

Please note: There are legal, ethical and organizational policy exceptions to confidentiality, which may require your therapist to release your records. We want you to be fully aware of these exceptions:

As a patient of PHMG Behavioral Health, certain information will be released within the organization; e.g. transcription of notes regarding your visits, charge slips sent to the billing department, communications with physicians or other Behavioral Health providers involved in your care. All employees of this organization are bound by a code of confidentiality. Your health insurance company may reserve the right to review your chart. Care is always taken to protect your rights to privacy. Effort is made to disclose to others the least amount of information needed in order to provide good care and insure reimbursement.

If there is reasonable cause to believe that you are an imminent danger to yourself or someone else, your therapist may arrange for a hospitalization or emergency medical consultation; **notify law enforcement authorities, other family members, and the individuals who may be at risk.**

In the case of a situation of abuse or neglect of a child or vulnerable adult, your therapist may **be required** by Oregon Law to report the situation to the appropriate authorities. If this is a concern for you, please discuss this issue with your therapist.

According to law, if, **at any time** your health status becomes an issue of a legal proceeding, including Worker's Compensation, your therapy records would be subpoenaed. A valid subpoena or court order may require the release of records or testimony by your provider.

If you become involved in legal proceedings or litigation against PeaceHealth, or any of its employees, please be aware that your clinical records may be made available to those involved in the investigation and defense of the organization.

Please initial the following if treatment pertains to a child:

If your minor child is in treatment, be aware that a non-custodial parent who wants to learn about their child's treatment may have the right, as does the custodial parent, to review the child's treatment record and to discuss their child's care with the therapist.

Mental Health services at PeaceHealth Medical Group do not include evaluation for the purpose of resolving legal disputes involving current and previous patients.

If you have specific concerns about confidentiality, please do not hesitate to speak to your provider about them.

I r**ead and understand the above. Client/Guardian initials:_________ Date: _____________**

Place patient label here

PeaceHealth patients (or patient representatives, as appropriate) have the right to…

- Choose from available services in a setting and under conditions that are least restrictive and intrusive to your liberty and that provide the greatest degree of freedom;
- Religious freedom;
- An individualized written service plan and ongoing participation in the planning of services;
- Deny services without informed voluntary written consent except in a medical emergency or as otherwise permitted by law;
- Receive medication only for your individual clinical needs;
- A humane service environment that provides reasonable protection from harm, reasonable privacy and daily access to fresh air and the outdoors. Access may be limited when it would create significant risk of harm to you or others.
- Receive prior notification of involuntarily termination or transfer of services and notification of available sources of necessary continued services;
- Decline to participate in experimentation without informed voluntary written consent;
- Be free from abuse or neglect and to report any incident of abuse without being subject to retaliation;
- Have access to and communicate privately with any public or private rights protection program or rights advocate.
- Know that, to enhance patient safety, video or auditory monitoring may be done in some individual patient rooms, care areas or common areas.

PeaceHealth patients (or patient representatives, as appropriate) are responsible to…

- Participate in planning and decisions regarding your healthcare;
- Provide as accurate and complete as possible relevant medical history, symptoms and concurrent conditions prior to and during the course of treatment;
- Ask questions and inform providers when answers to questions are not clear or understood or if you cannot follow instructions or the treatment plan;
- Promptly report any changes in your health, concerns about their care and/or obstacles to following your treatment plan;
- Provide information necessary to determine the ability to pay for services and any other sources of payment for services;
- Respect the dignity and rights of others;
- Respect the property of other persons and of the medical center;
- Conduct yourself in a respectful way that protects and maintains the safety of the healthcare environment;
- Do your best to follow your agreed upon treatment plan to reach the best possible outcome of care;
- Respect and comply with the PeaceHealth Tobacco-Free Campus Policy.

Treatment Plan
You have the right to participate in forming your treatment plan and to ask why any form of treatment is recommended. You may at any time refuse treatment or request a change in the treatment approach. Please discuss this further with your provider.

Appointments & Emergencies
It is your responsibility to attend scheduled appointments. If you cannot keep your appointment, please call and cancel at least 24 hours prior to your scheduled appointment time.

If you have an urgent need during business hours, you may be referred to another Behavioral Health care provider. We typically cannot be interrupted in the middle of a session with another client. On the weekends or after hours, our answering service can locate us, and your call will be returned within 24 hours. If your provider is unavailable, you may be referred to another provider who is on call. In an afterhours emergency, if you can't reach a Behavioral Health provider, go to the Urgent Care Center at PeaceHealth Medical Group or to the Emergency Room at Sacred Heart Medical Center.

Therapy Fees
Our standard hourly fee is $401.00 for psychiatrists, $401.00 for nurse practitioners, $349.00 for licensed psychologists and $349.00 for licensed clinical social workers, psychologist associates and professional counselors.

However, charges will vary depending on the length and type of session (e.g. initial visits, family or group therapy). **The average therapy session is approximately 45 to 50 minutes in length.** You may also be charged for other services such as testing, phone calls, after-hour contacts and consultations with other professionals. Please feel free to discuss charges or fees with us. Your insurance company will be billed for covered services; however, you will be expected to pay for any fees which are not covered by insurance.

Provider Responsibility Disclaimer
I understand many insurance companies now require authorization for mental health services. I will notify my provider if my insurance company requires pre-authorization. It is the provider's responsibility to submit the necessary treatment plans in order to obtain pre-authorization; however, it is my responsibility to be aware of my insurance company's pre-authorization requirements and how many actual benefits I have remaining. Authorization for sessions does **NOT** guarantee available benefits. If my benefits run out, I will be personally responsible for my bill.

Client/Guardian initials: **Date:**

Health Record Information
I understand my health care provider may enter protected health information related to my treatment into the PeaceHealth electronic record system.

I read and understand the above. Client/Guardian initials: ________ Date: _____________

Risks & Benefits of Therapy

Therapy has both benefits and risks. Therapy has been shown to have benefits such as improved mood or relationships and resolutions of specific problems. Risks may include experiencing uncomfortable emotions such as sadness, anxiety or anger, recalling difficult aspects of your history or disapproval of significant others. There are no guarantees about how therapy will affect you.

Grievance Procedures
If you feel your rights have been violated, please discuss this with your provider. If you are not able to resolve the issue in this manner, you may discuss it with the Behavioral Health Manager (458-205-6444) or the Behavioral Health Regional Director (541-686-7376). Finally, if a grievance cannot be resolved in this manner, you should contact the Oregon State Board of Medical Examiners, the Oregon State Board of Psychological Examiners, the Oregon State Board of Clinical Social Workers, the State Board of Nursing or the State Board of Licensed Professional Counselors and Therapists.

Oregon Health Plans Declaration of Mental Health Treatment
The Declaration for Mental Health Treatment is an advance directive that allows consumers to make choices about the mental health treatment they may want to receive at some future time, when and if they are not capable of giving consent. It also lets a consumer appoint a friend or relative to make these choices for him or her. A completed Declaration form allows a doctor to treat a consumer even though the consumer cannot provide consent at the time. Declaration for Mental Health Treatment forms can be obtained by contacting the State of Oregon, Office of Addictions and Mental Health Division (AMH), 500 Summer Street NE, E86 Salem, Oregon 97301-1118. Phone: 541-945-5763 https://www.oregon.gov/oha/HSD/OHP/Pages/Member-Rights.aspx

Oregon Medicaid Clients Only:

I have received and signed a Declaration ❑	I do not wish to sign a Declaration at this time ❑
Client/Guardian initials:	**Date:**

Advance Directive
Advance Directives are available at every PeaceHealth office. Please ask the receptionist for assistance.

I have read and understand the Client Rights and Responsibilities Statement included herein. I give the PeaceHealth Medical Group Behavioral Health Services permission to evaluate or treat me or my family.

I have received a copy of the "Client Rights and Responsibilities" form.
[ ] PeaceHealth Medical Group "Your Rights As A Patient" form given on Admission.

____
Signature Patient/Person Authorized to Sign for Patient – Relationship Date Time

____
Signature Patient/Person Authorized to Sign for Patient – Relationship Date Time

____
Signature Patient/Person Authorized to Sign for Patient – Relationship Date Time

____
Caregiver Signature EHR User ID Date Time

For staff use only: Interpreter services and/or special accommodations were provided?
❑ Yes ❑ No, Not Needed