New Directions® Northwest Inc.

Administrative Office
(541) 523-7400Fax: (541) 523-4927
2100 Main Street, P.O. Box 1005,
Baker City, OR 97814
www.newdirectionsnw.org
Chief Executive Officer: Shari Selander

Outpatient Services (541) 523-3646
2200 Fourth Street, Baker City, OR

"Committed to serve and support the behavioral health needs of our communities."

Welcome to Behavioral Health & Wellness!

We want to welcome you to New Directions Behavioral Health & Wellness. We know that for most people, coming for help for your problems is not an easy thing to do. We want to thank you for coming, and let you know that we want to do whatever we can to get to know you and help you to feel hopeful that your issues can be addressed. Our goal is to help you identify and address all your concerns-no matter what they are, in order that you might have the happiest and most meaningful life that you can!

Request for Help: What is it you most want us to help you with? Please describe in as much detail as you can.

Hopeful Goals: What is your vision of your most hopeful, happy and productive life, or your most important life goals? How would you like to make progress toward those goals? Please describe in as much detail as you can.

Are you interested in work? *Would you like to learn more about our employment services*?

Mental Health?		DUII?	
Substance Abuse?		Court Ordered?	
Child Welfare Involved?		Primary Physician Referral?	

New Directions® Northwest Inc.

Client Information

Name: _____DOB: _____Last Name at Birth:_____

Home Address: _____City: _____State: ___ ZIP: _____

SS#:_____Driver's License #:_____Gender: ☐ M☐ F

Home Phone:_____ Primary Language:_____ Birth Place:_____

Marital Status: ☐Married ☐Divorced ☐ Separated☐ Widowed ☐ Never MarriedReligion:_____

Race: ☐Not of Hispanic Origin ☐ Cuban ☐ Mexican ☐Other Hispanic☐ Puerto Rican☐ Unknown

Ethnicity:☐Alaska Native☐ American Indian☐Asian☐Black/African American☐Other Single Race
☐NativeHawaiian/ Other Pacific Islander☐Two or More Races☐Unknown☐White

Forensic Court Ordered Treatment:☐Civil Court Ordered☐Court Ordered Evaluation/Assessment Only
☐Not Applicable☐Criminal Court Ordered☐Unknown/Declined to Answer

Co-Occurring Problems?☐Y ☐NRegistered Sex Offender: ☐Y☐NMH Advanced Directive:☐Y☐N

Employment Status: ☐Fulltime☐Part-time☐Unemployed SEEKING Work☐Unemployed NOT SeekingWork
☐Student☐Homemaker☐Retired☐Disabled☐Unknown

Highest Level/Grade of Education Completed: _____Have you ever served in the Military?☐Yes☐No

Number of Employers last 12 months: _____ Registered Voter? ☐Yes☐No

Number of arrests in last 30 days? _____ Number of arrests in the last 12 months? _____

Justice System Involvement? ☐Arrested☐Charged with a Crime☐Jail Detained☐Jail-Incarcerated
☐Other☐Unknown

Client Type: ☐ Outpatient Co-Occurring ☐ Outpatient MH ☐ Outpatient SUD
☐ Residential SUD ☐ Residential Co-Occurring

SSI/SSD Status: ☐ Determined ineligible ☐ Eligibility Determination Pending ☐ EligibleNot Receiving Payments
☐ Eligible Receiving Payments ☐ Not Applicable ☐ Potentially Eligible has Not Applied

Living Arrangements: ☐ Jail ☐ Homeless ☐ Private Residence Independent ☐ Private Residence Dependent

Tobacco Use: ☐Current Everyday ☐Current Someday ☐Former Smoker☐ Never Smoked ☐ Uses Smokeless Tobacco

Primary Care Physician: _____ Previous MH and/or SUD treatment: _____

Referral Agency:_____ Contact Name:_____ Phone:_____

Address:_____ City:_____ State: ____ Zip: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Address: _____ City:_____State:____ Zip:_____

_____ _____
Staff Signature Date Client Signature Date

_____

Parent/Guardian Signature Date

Insurance Information & PHI Consent for Use and Disclosure

Name:	SSN:	DOB:

Primary Insurance Information:

Are you covered by any of the following insurance? *(Check appropriate boxes)*

Medicare ☐ Medicaid DMAP ☐ Medicaid EOCCO ☐ Blue Cross ☐ Other Public ☐ Other Private ☐ None ☐

Name of Insurance: _____ Policy Number: _____ DOB: _____

Address: _____ City, State & Zip: _____ Phone: _____

Subscriber Name: _____ SSN#: _____ Relationship: _____

I authorize the release of any treatment information necessary to process insurance claims. Furthermore, I authorize direct payment of health care benefits to New Directions Northwest, 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.

Guarantor Signature: X _____ Date: _____

Secondary Insurance Information:

Name of Insurance: _____ Policy Number: _____ DOB: _____

Address: _____ City, State & Zip: _____ Phone: _____

Subscriber Name: _____ SSN#: _____ Relationship: _____

I authorize the release of any treatment information necessary to process insurance claims. Furthermore, I authorize direct payment of health care benefits to New Directions Northwest, 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.

Guarantor Signature: X _____ Date: _____

Notice of Privacy Practices, Individual Rights, Grievance Process, Rules & Expectations and OHA Declaration for Mental Health Treatment

By signing below, I acknowledge receipt of the New Directions Notice of Privacy Practices, Individual Rights, Rules & Expectations and Grievance Process. I also acknowledge receipt of Oregon Health Authority: Declaration for Mental Health Treatment.

X _____ _____ _____

Signature of Client, Client's Parent or Guardian, or Client's Personal Representative | Date Signed | If Not Signed by Client, Indicate Relationship of Person Signing to Client

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 New Directions 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 or my CCO) 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 substance use disorder treatment program services for such treatment, payment and health care operations purposes. I understand that this consent to use and disclose information expires when I terminate treatment and that I may revoke this consent prior to that time, except to the extent to which New Directions has taken action 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 _____ _____ _____

Signature of Client, Client's Parent or Guardian, or Client's Personal Representative | Date Signed | If Not Signed by Client, Indicate Relationship of Person Signing to Client

New Directions® Northwest Inc.

Administrative Office
(541) 523-7400 Fax: (541) 523-4927
2100 Main Street, P.O. Box 1005,
Baker City, OR 97814
www.newdirectionsnw.org
Chief Executive Officer: Shari Selander

Outpatient Services (541) 523-3646
2200 Fourth Street, Baker City, OR

"Committed to serve and support the behavioral health needs of our communities."

Behavioral Health and Wellness & Total Health

APPLICATION TO DETERMINE DISCOUNTED FEE SCALE ELIGIBILITY

Name: _____ DOB: _____

Your response to the following questions will help NDN determine if you might be eligible for reduced fees. If you do not respond to all questions, or if you furnish information that is inaccurate or incomplete, this form will be considered invalid. *Completing this application does not assure that you will be eligible for discounted fees.*

1. Are you employed? ___Yes ___no

2. List and provide proof of any income received by yourself and others that contributes to your household income. "Household income" is all income you depend upon.

YOUR employment (wages/salary)	$_____
Gambling Income	$_____
Others' employment (wages/salary)	$_____
Unemployment Compensation	$_____
Public Assistance (SNAP, TANF)	$_____
Social Security	$_____
Worker's Compensation	$_____
Retirement Funds/Pensions	$_____
Veteran's Benefits	$_____
Supplemental Security Income (SSI)	$_____
Alimony/Child Support	$_____
Others_____ (specify)	$_____
Total	$_____

3. Total number of people dependent upon the income listed in question 2. _____

Acknowledgement of Understanding

The information I have provided is true. I understand that completing this form does not necessarily assure that I will receive reduced fees.*(Note: Eligibility will need to be re-determined at the end of each calendar year.)*

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

New Directions® Northwest Inc.

Behavioral Health and Wellness & Total Health

SLIDING FEE SCHEDULE*

Table 1 - Monthly Income Categories								
Payment Code→	A	B	C	D	E	F	G	H-UCR
Family Size 1	$0-$903	$904-$981	$982-$1,471	$1,472-$1,716	$1,717-$1,962	$1,963-$2,207	$2,208-$2,452	$2,453-+
2	$0-$1,214	$1,215-$1,328	$1,329-$1,991	$1,992-$2,223	$2,224-$2,655	$2,656-$2,987	$2,988-$3,319	$3,320-+
3	$0-$1,526	$1,527-$1,674	$1,675-$2,517	$2,518-$2,980	$2,931-$3,348	$3,349-$3,767	$3,768-$4,185	$4,186-+
4	$0-$1,838	$1,839-$2,021	$2,022-$3,031	$3,032-$3,536	$3,537-$4,042	$4,043-$4,547	$4,548-$5,052	$5,052-+
5	$0-$2,149	$2,150-$2,368	$2,369-$3,551	$3,552-$4,143	$4,144-$4,735	$4,736-$5,327	$5,328-$5,919	$5,920-+
6	$0-$2,461	$2,462-$2,714	$2,715-$4,071	$4,072-$4,750	$4,751-$5,428	$5,429-$6,107	$6,108-$6,785	$6,786-+
7	$0-$2,773	$2,774-$3,061	$3,062-$4,591	$4,592-$5,356	$5,357-$6,122	$6,123-$6,887	$6,888-$7,652	$7,653-+
8+	$0-$3,092	$3,093-$3,408	$3,409-$5,111	$5,112-$5,963	$5,964-$6,815	$6,816-$7,667	$7,668-$8,519	$8,520-+

Table 2 - Sliding Fee Per Session – *Mental Health Rates*								
Payment Code→	A	B	C	D	E	F	G	H-UCR
Psychiatrist/PMHNP-Medication Evaluation	30.00	45.00	90.00	120.00	150.00	225.00	270.00	300.00
Psychiatrist/PMHNP-Medication Management	15.00	23.00	45.00	60.00	75.00	113.00	135.00	150.00
QMHP-Individual: 53 minutes or longer	27.00	40.00	81.00	108.00	135.00	202.00	242.00	269.00
QMHP-Individual: 52 minutes or less	18.00	27.00	54.00	72.00	90.00	134.00	161.00	179.00
QMHP-Group	7.00	10.00	21.00	28.00	35.00	52.00	62.00	69.00
QMHA-Group	5.00	8.00	15.00	20.00	25.00	38.00	45.00	50.00
Pain Management - Assessment	40.00	60.00	121.00	161.00	201.00	302.00	363.00	403.00
Pain Management – ED Group	21.00	31.00	62.00	83.00	104.00	156.00	187.00	208.00
Pain Management - Individual	18.00	27.00	54.00	72.00	90.00	134.00	161.00	179.00
Pain Management – Movement Therapy	18.00	27.00	54.00	72.00	90.00	134.00	161.00	179.00

Table 3 - Sliding Fee Per Session – *Alcohol & Drug Rates*								
Payment Code→	A	B	C	D	E	F	G	H-UCR
Assessment	17.00	26.00	51.00	68.00	85.00	128.00	153.00	170.00
Group per Hour	4.00	6.00	12.00	16.00	20.00	30.00	36.00	40.00
Individual per Hour	9.00	13.00	26.00	35.00	44.00	66.00	79.00	88.00
UA test – Flat Rate	$35.00							

Client assumes responsibility to pay for services received at NDN,fees from _____ Column (**refer to Tables 2 & 3**). If the situation arises that an individual has an outstanding debt of $100.00 or more, services will be limited to Crisis Services only and the delinquent account will be turned over to collections.

☐I agree to pay fees outlined above at the time of the appointment.

☐I agree that the above information is accurate and current.

Client Name _____ Date _____

Client Signature _____ *Effective: May15, 2018

New Directions Behavioral Health and Wellness

Rules and Expectations for Substance Used Disorder Treatment

☐ I agree to abstain from the use of alcohol and all other mood altering drugs/gambling.

☐ Use of alcohol and/or drugs and/or gambling will result in a review of my case with possible discharge from the program or recommendation for a higher level of care (includes all treatment levels, DUII and MIP). Abstinence is defined as providing urine, oral swabs, breathalyzer and/or other approved tests, **free from all non-prescribed, non-facility approved medications, alcohol and all other mood altering drugs**.

☐ If Marijuana is a prescribed medication please complete and follow the Medical Marijuana Treatment Agreement and Policy. Consistent with OAR 309-019-0195 DUII treatment cannot begin until abstinence is verified. All positive tests for medications will be considered positive and unauthorized until a prescription or prescription bottle with the individual's name on it is provided for photocopying by staff. Consistent with ORS 813.200 Medical Marijuana does not qualify as an allowable intoxicant/medication and cannot be used during DUII treatment/diversion.

☐ Use or attempted use of foreign substances or body fluids other than the individual being tested will result in documentation of the event, possible report to referring agency, possible increase in level of care, and/or possible discharge from the program.

☐ I will participate in all sessions and be on time with all required homework/packets completed.

☐ I agree to make up any sessions I miss.

☐ I will contact New Directions Behavioral Health & Wellness at (541) 523-3646 a minimum of one hour before group to inform staff if I am not going to be able to attend.

☐ If I miss a scheduled one-on-one with my counselor, I may be contacted by phone by my counselor and charged for a consult. When possible, I will give 24 hour notice before missing my appointment.

☐ If I am a no-show for any scheduled appointment or group without PRIOR approval I may be held financially responsible for that appointment and my referring agency may be contacted as applicable.

☐ I agree to a breathalyzer test at staff request. If I fail to take the test or refuse I may be asked to leave the building. I understand that this will be treated as a positive result.

☐ I agree to submit a urine/saliva sample at staff request. If I fail to leave a sample or refuse I understand that this will be treated as a positive result. I also understand that a dilute sample is a positive result.

New Directions Behavioral Health and Wellness

Rules and Expectations for Substance Used Disorder Treatment – Page 2

☐ I understand that I am required to call the UA Line every week day and if I am required to test I will provide a UA sample at the outpatient office between the hours of 8:00 AM and 10:00 AM or 4:00 pm to 6:00 pm that same day(8:00 AM and 10:00 AM or 4:00 pm to 5:00 pm Friday). **Failure to provide a sample will be considered as a positive test result.** The UA line phone number is (541) 249-7203.

☐ I understand that any break of confidentiality may result in termination from treatment.

☐ I understand that abusive and/or violent behavior will not be tolerated and will result in my immediate termination.

☐ I understand that three unexcused absences may result in my termination from the program.

☐ I understand that building romantic relationships with other treatment participants is prohibited and could result in my termination from treatment.

Payment is due at the time of service, prior to attending an assessment or treatment session. If you have private insurance we can help you check your copay, coinsurance and/or deductible. You will be required to provide payment at usual and customary rates prior to receiving any services. If you are court ordered to mental health treatment are required to provide usual and customary court ordered fees prior to receiving treatment. If you **do not** have insurance coverage you may qualify for the indigent sliding fee scale.

I have read the above rules and expectations and understand their intent. I agree to abide by these expectations and have received a copy of them for future reference.

_____	_____	_____
Individual (Signature)	Individual (print name)	Date
_____	_____	_____
Parent or Guardian (Signature)	Parent or Guardian (print name)	Date
_____	_____	_____
NEW DIRECTIONS Staff (Signature)	NEW DIRECTIONS Staff (print name)	Date

New Directions® Northwest Inc.

Administrative Office
(541) 523-7400
Fax: (541) 523-4927
2100 Main Street, P.O. Box 1005
Baker City, OR 97814
www.newdirectionsnw.org
Chief Executive Officer: Shari Selander

"Committed to serve and support the behavioral health needs of our communities."

SUD CLIENTS: Concurrent Treatment -Authorization to Use or Disclose Protected Health Information (page 1 of 3)

SECTION A: ***The name of the person, or class of persons, who may authorize the requested use or disclosure.***

I, _____or my authorized representative, authorize New Directions Northwest to disclosure my protected health information as described in Section B below**.** I understand that:

1. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this use or disclosure.
2. I am entitled to a copy of this authorization.

SECTION B: ***Entities Authorized to Receive or Use the Individual's Protected Health Information*****:**

Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing us to disclose the protected health information described below:

☒NDN staff members who need access to my integrated health record for mental health services.

SECTION C: ***Protected Health Information that may be Viewed, but not Perused*****:**

Specifically and meaningfully describe the protected health information you are authorizing to be accessible to mental health staff.

☒Should I enroll concurrently in mental health and substance abuse treatment services with NDN, I am authorizing access to my integrated health record by mental health staff only for minimally necessary purposes such as payment, operations and integrated care, recognizing that my substance abuse treatment information is included in the same record.

SECTION D: ***Purpose of the Use or Disclosure*****:**

Describe the reason for the use or disclosure of this information.

☒I understand that my substance abuse treatment records, and the fact that I am receiving treatment in a federally assisted substance abuse treatment program, is protected by federal law.However, I also understand that NDN has an integrated health record which allows mental health staff access to the health information related to my substance abuse treatment if I am also receiving, or have received mental health services from NDN. I am therefore authorizing NDN staff members who need access to my health record for purposes related to my mental health

SUD CLIENTS: Concurrent Treatment - Authorization to Use or Disclose Protected Health Information (page 2 of 3)

treatment to access the minimum necessary health information in my record that is needed for such purposes, with the assurance that my substance abuse treatment information will not be perused and the fact that I am receiving substance abuse treatment will not be disclosed.

SECTION E: *Expiration and Revocation*.

This authorization will expire (complete one):

- ☐ On _____/_____/_____
- ☐ On occurrence of the following event (which must relate to the individual or to the purpose of the disclosure being authorized):

_____

_____

Right to Revoke:

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the contact office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office:	New Directions Behavioral	Health & Wellness
Telephone:	541-523-3646	Fax:541-523-7602
Email:	N/A	
Address:	2200 4th St	Baker City, OR 97814

SECTION F. *Redisclosure*

This information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information 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 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SECTION G. Conditioning Treatment on Signing this Authorization.

NDN may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form.

SUD CLIENTS: Concurrent Treatment - Authorization to Use or Disclose Protected Health Information (page 3 of 3)

SECTION H. *Signature*.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Description of Authority to Act for the Individual: _____

_____

_____

_____ _____ _____

NEW DIRECTIONS Staff (Signature) NEW DIRECTIONS Staff (print name) Date