



New Directions
Northwest Inc.

3425 13th Street, Baker City, OR 97814

Office: (541) 523-7400

Fax: (541) 523-4927

◆Crisis 24/7: (541) 519-7126◆

www.newdirectionsnw.org

Chief Executive Officer: Shari Selander

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

Outpatient Services

Crisis Line 24/7: (541) 519-7126

Intake Packet

Mental Health



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Name: First: _____ Middle: _____ Last: _____

Birth Name (if different): _____ **Birthplace:** _____

SSN: _____ **DOB:** _____

Sex: _____ **Gender Identity:** _____

Sexual Orientation: _____ **Preferred Pronouns:** _____

Medicaid/OHP ID: _____ **License/ID#:** _____

Referral From: _____ **Phone Number:** _____

Contact Information:

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **County:** _____

Phone #: _____ **For Voice/SMS Reminder:** Yes ___ No ___

Message #: _____ **Contact Email:** _____

Primary Care Provider: _____ **Clinic/Office Name:** _____

Emergency Contact:

Name (First and Last): _____ **Relationship:** _____

Address: _____ **City:** _____ **County:** _____

State: _____ **Zip Code:** _____ **Home #:** _____

Work #: _____ **Cell #:** _____ **Other #:** _____

Responsible Party Contact:

First Name: _____ **Middle Name:** _____

Last Name: _____ **DOB:** _____ **SSN:** _____

Address: _____ **City:** _____ **County:** _____

State: _____ **Zip Code:** _____ **Sex:** _____ **Relationship:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Demographics:

Marital Status: Never Married___ Married___ Separated___ Divorced___ Widowed___

Living Arrangement: Transient/Homeless___ Foster Home___ Supported Housing___ Private Residence___
Living with relatives___ Living with non-relatives___

Ethnicity: Alaska Native___ American Indian___ Asian___ Black African American___

Native Hawaiian___ Other Pacific Islander___ Two or more races___ Unknown___ White___ Decline___

Race: Not of Hispanic Origin___ Cuban___ Mexican___ Other Hispanic___ Puerto Rican___ Decline___

Tribal Affiliation (if applicable): _____ **Primary Language:** _____

Migrant/Seasonal: Yes___ No___ **Religion:** _____ Decline___

Highest Grade Completed: _____ **Pregnant:** Yes___ No___ N/A___

Tobacco Use: Yes___ No___ **Do you need an interpreter?** Yes___ No___

Total Number of dependents including yourself: _____ **Number of Child dependents:** _____

Employment: Fulltime___ Part-time___ Unemployed-Seeking work___ Unemployed-Not seeking work___ Student___

Homemaker___ Other___ **Veteran:** Yes___ No___ **Registered Voter:** Yes___ No___

Would you like voting information? Yes___ No___

Occupation: _____ **Employer Name:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Source of Income / Support: Wages/Salary___ Public Assistance___ Retirement/Pension/SSI___

Disability/SSDI___ Other___ None___ Unknown___

Estimated Gross Household Monthly Income: _____ Decline to Answer___

Justice System Involvement (court-ordered)? Yes___ No___

Probation officer name: _____ **County:** _____

Total arrests: _____ **Total Number of DUII Arrests:** _____ **Sex Offender:** Yes___ No___

Services you are seeking today: _____

Client/Guardian or Parent Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I _____ (name of client) hereby consent to engaging in telemedicine at New Directions Northwest, Inc. (NDN) as part of my mental health psychotherapy or addictions treatment. I understand that 'telemedicine' includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health and addiction information, both orally and visually, to other health care practitioners within NDN.

Technology: I understand that I will need to download an application and/or software to use the Zoom platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact NDN via phone to coordinate alternative methods of treatment.

Clients using insurance: I am responsible for connecting my insurance company, if applicable, to determine what my out-of-pocket costs may be. I authorize insurance benefits to be paid directly to NDN and that NDN may release any information to my insurance provider required for processing my claims. Client Initial: _____

I understand that using the Telemedicine platform allows access to mental health and addiction services that might not otherwise be available to me due to my mental health, addiction, and /or my physical, resource, or geographic limitations, or current public health concerns that exist within our community.

Scheduling: I understand that scheduling is conducted through NDN and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the NDN Crisis Line at: (541) 519-7126.

Video/Audio Recording: As a general practice NDN DOES NOT record Telemedicine sessions without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threat of violence towards an ascertainable victim; and where I made my mental or emotional state an issue in a legal proceeding. NDN's Telemedicine platform is HIPAA compliant to protect my privacy and confidentiality.

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withdraw my consent at any time.
2. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my geographic area.
3. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured.
4. I understand that NDN may not provide telemedicine services to me if I am outside of the State of Oregon and I understand that I may access telemedicine services from NDN from within the State of Oregon only.
5. I understand that I have a right to access my mental health information and copies of medical records in accordance with Oregon state law.

I have read and understand the information provided above. I have discussed it with my counselor/therapist/clinical intern, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

Client/ Parent/Guardian Signature _____ Date _____

Provider's name and Signature _____ Date _____

Confirmation of Receipt of HIPAA Notice

Client's Name

Federal guidelines under the **Health Insurance Portability and Accountability Act (HIPAA)** now require that as a health care provider, New Directions Northwest, Inc. is to provide you with a **WRITTEN COPY** of HIPAA Notice, informing you of your rights and protections of Behavioral Health services with New Directions Northwest, Inc.

Written confirmation that you have received this Notice is required.

By your signature below, you confirm that you have received a copy of HIPAA Notice as required by law.

I was given a copy of the Privacy Policy:

- DECLINED A COPY**
- ACCEPTED A COPY**

Individual's Signature

Date

Witness Signature

Date

The NORC* Diagnostic Screen for Gambling Problems – Page 1 of 2

This is a mandatory form, please complete it entirely

Instructions: For each question asked, circle YES or NO.

1. Have there ever been period lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences, or planning out future gambling ventures or bets? 1
YES SKIP TO 3
NO GO TO 2
2. Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about ways of getting money to gamble with? 2
YES
NO
3. Have there ever been periods when you needed to gamble with increasing amounts of money or with larger gets than before in order to get the same feeling of excitement? 3
YES
NO
4. Have you ever tried to stop, cut down, or control your gambling?
YES GO TO 5
NO SKIP TO 8
5. On one or more of the times when you tried to stop, cut down, or control your gambling, were you restless or irritable? 5
YES
NO
6. Have you ever tried *but not succeeded* in stopping, cutting down, or controlling your gambling?
YES GO TO 7
NO SKIP TO 8
7. Has this happened three or more times? 7
YES
NO
8. Have you ever gambled to relieve uncomfortable feelings such as guilt, anxiety, helplessness, or depression? 8
YES SKIP TO 10
NO GO TO 9
9. Have you ever gambled as a way to escape from personal problems? 9
YES
NO
10. Has there ever been a period when, if you lost money gambling one day, you would often return another day to get even? 10
YES
NO

The NORC Diagnostic Screen for Gambling Problems– Page 2 of 2

11. Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling?
YES GO TO 12
NO SKIP TO 13
12. Has this happened three or more times? 12
YES
NO
13. Have you ever written a bad check or taken money that didn't belong to you from family members or anyone else in order to pay for your gambling? 13
YES
NO
14. Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends? 14
YES SKIP TO 17
NO GO TO 15
15. Has your gambling ever caused you any problems in school, such as missing classes or days of school or your grades dropping? 15
YES SKIP TO 17
NO GO TO 16
16. Has your gambling ever caused you to lose a job, have trouble with your job, or miss out on an important job or career opportunity? 16
YES
NO
17. Have you ever needed to ask family members or anyone else to loan you money or otherwise bail you out of a desperate money situation that was largely caused by your gambling? 17
YES
NO

http://www.ncrg.org/sites/default/files/uploads/docs/monographs/nods_full.pdf

NORC a national organization for research at the University of Chicago

Client Signature: _____ **Date:** _____