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

SUD & MH

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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 #:_____

Na me: First : ___ ___

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:_____

Client 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 Insured (if not the client): _____

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

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 _____

Rules and Expectations for Substance Use 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 at (541) 523-7400 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.

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 5:00 PM. **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

SUD CLIENTS: Concurrent Treatment - Authorization to Use or Disclose Protected Health Information (page 1 of 2)

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 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):

☐ One year from date signed
☐ On completion of treatment
☐ Other, specify: _____

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 Northwest, Inc.
Telephone:	541-523-7400 FAX: 541-523-4927
Email:	N/A
Address:	3425 13th Street, 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.

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

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.

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:_____