Client #:_____

Options
Counseling and Family Services

ACKNOWLEDGEMENT OF POLICY

Notice of Privacy Practices

The Notice of Privacy Practices tells you how Options Counseling & Family Services may use or share information about you. Not all situations will be described. Options is required to offer you a notice of our privacy practices for the information we collect and keep about you.

Confidentiality

I understand that the information that I share with my treatment provider will remain confidential in accordance with Oregon and Federal rules and law,[1] unless I provide written permission to release information. Exceptions to this are stated below:

- The receipt of information that suggests that there has been abuse or neglect of a child, elder or adult with a mental illness or disability. This includes a requirement to report intimate partner violence, sexual assault of an adult, and violence witnessed by a child under 18.
- The threat of harm to self or others. This may include warning a person threatened with harm, or disclosure of necessary health information to a person, agency or authority, who has the capacity to deal with the danger (law enforcement, hospitals, protective service agencies).
- My information may be reviewed by my health plan, including the Oregon Health Authority or the local coordinated care organization for authorizing services, quality improvement, utilization management, and site review. Individuals providing physical health care may also review my information.
- In order to provide individual follow-up within the coordinated care network, information about my hospital utilization, including visits to the emergency department, admissions, and discharges, will be shared with my Options provider.
- My information, including HIV and other health and mental health diagnoses, may be shared within the coordinated care network for the purpose of providing whole-person care.
- In the event of a medical emergency, Options may release information. This is limited to that which is judged necessary to resolve the emergency and assist in my care by the attending emergency worker.
- In case of psychiatric hospitalization, information about my mental health status prior to entering the hospital, and information judged to be helpful in planning for my discharge from the hospital, may be released.
- Information may be released upon valid court order.
- If I file a legal claim or formal complaint or action against Options relating to services received.

By initialing I agree that I have read and understand this section.
I have also been offered a copy of The Notice of Privacy Practices, which has been verbally explained to me.

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Client Initials

Electronic Communication Policy

Some clients have requested that we communicate with them via e-mail or text message. Information contained in e-mail and text messages isn't guaranteed to remain confidential due to the limitations of the Internet and electronic media. Our staff may only use email or text for scheduling, re-scheduling, or cancellation and the communications should not contain information that would normally be part of the session with your provider. I understand that the electronic information that I share with my treatment provider, including copies or summaries of email and text messages, will be maintained in my file according to state regulations governing mental health records.

By initialing I agree that I have read and understand this section.

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Client Initials

[1] Including ORS 107.154, 179.505, 179.507, 192.515, 192.507, 414.679 and 42 CFR Part 2 and 45 CFR Part 205.50.

Client #:_____

ACKNOWLEDGEMENT OF POLICY

Travel Release and Waiver

In the course of receiving services Options may be available to provide transportation to myself or my child(ren), when it is appropriate for treatment. I understand that Options transportation is only available to the identified client and their guardian (if client is a minor) and that I am not required to use an Options provider for transportation. If I decide to use Options for transportation I agree to hold the provider and the agency harmless in the event of accidents, injuries, or death which may occur in the course of such travel.

By initialing I agree that I have read and understand this section:

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Client Initials

Missed Appointment Policy

In order to meet treatment goals, it is important to attend all scheduled sessions. Occasionally it is difficult to attend a scheduled appointment. When that happens, I understand that I am expected to call to reschedule 48 hours or more before the appointment time. I understand that, at Options, a missed appointment is defined as either canceling or rescheduling an appointment with less than 48 hours' notice or failing to attend a scheduled appointment without any notification.

I understand that if I miss two or more appointments with less than 48 hours' notice, my Options provider, Resource Specialist, or Case Manager may contact me to discuss participation. Services may be offered to me with the intent to identify and address barriers to attendance and evaluate the goals of therapy. I understand that if I do not participate in these services, my case may be closed and any future appointments canceled.

By initialing I agree that I have read and understand this section:

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Client Initials

STATEMENT OF FINANCIAL RESPONSIBILITY

The law requires that Options Counseling & Family Services make an effort to collect any third party (private insurance) benefits you/your child may be entitled to before billing Medicaid/Oregon Health Plan (OHP) or Medicare. This includes benefits provided by a custodial, non-custodial, out of state, or absentee parent. It also includes benefits for services provided as the result of personal injury and covered by a personal injury protection policy such as automotive insurance.

Most insurance companies, including OHP, require prior and ongoing authorization for Options Counseling & Family Services. I understand that failure to notify Options of changes to insurance coverage may impact my ability to receive care. I agree to notify Options of any changes, or anticipated changes, to insurance coverage while I, or my child, is receiving services from Options. This includes changes to existing coverage, termination of coverage, or new coverage (either private or OHP).

I understand that I am responsible for the deductible, co-pay, co-insurance, and/or any other financial obligations not covered by third party insurance or OHP. I understand that I am responsible for understanding my insurance benefits and that any benefit summary Options or my insurance company provides to me is not a guarantee of benefit availability or payment. If costs are incurred by Options to collect balances I owe, I understand I may be liable for the associated fees. I assign to Options any benefits paid to me by my insurance company for services provided by Options. This assignment will remain in effect until revoked by me in writing.

By initialing I agree that I have read and understand this section:

_____
Client Initial

Client #:_____

ACKNOWLEDGEMENT OF POLICY

As a behavioral health client in the State of Oregon I have been informed of my rights to receive information about the following entitlements and policies:

Voter Registration Information (For clients 18 years of age at the next election):	_____ Client Initials
Information about Advance Directive (**adult clients only**):	_____ Client Initials
Declaration of Mental Health Treatment: (**adult clients only**):	_____ Client Initial
I would like to develop a Declaration for Mental Health Treatment:	Yes _____ No _____

_____ _____

Signature of Individual (or Parent/Guardian if applicable) **Date**