

**IDENTIFYING INFORMATION:**

Full name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Preferred name to be called: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Family Composition** – Please list all the adults and children in the home.

Is this home (check one)  Biological  Foster  Adopted  Other

<u>Name</u>	<u>Birthdate</u>	<u>Relationship</u>	<u>Mental Health Diagnosis?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MILITARY SERVICES:**

Have you served in the military?  Yes  No

**ACADEMIC AND EMPLOYMENT HISTORY:**

What is the highest level of school completed?

Grade 6 7 8 9 10 11 12 GED College 1 2 3 4 5 6 Other: \_\_\_\_\_

Current occupation: \_\_\_\_\_ Current employer: \_\_\_\_\_

Years/months at this position: \_\_\_\_\_

Previous occupation: \_\_\_\_\_

Years/months at this position: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

Place patient label here

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PeaceHealth Medical Group  
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History Form (Age 18+)  
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BH Clinic Note

## Symptom List

Below is a list of common problem areas. Please check all that you have experienced in the past month.

- Aggressive thoughts/statements
- Angry or temper difficulties/hostile
- Anxious, tense, worried, fearful
- Down or depressed
- Easily upset
- Loss of interest or pleasure, withdrawn
- Low self-esteem, self-critical
- Loss of sexual interest/performance
- Homicidal thoughts/statements
- Unusual noises or images
- Feeling that your mind is “racing”
- Difficulty completing thoughts
- Obsessive thoughts
- Compulsive behaviors
- Fearful dreams
- Physically assaultive behaviors
- Relationship conflicts/social problems
- Feel unsafe in home
- Concentration difficulties
- Memory problems
- Unusual, troubling or inappropriate sexual interest

### **Sleeping difficulties**

*(check those which apply)*

- Sleeping too much
- Difficulty falling asleep
- Frequent awakening during night
- Early morning awakening

### **Change in appetite/eating**

*(check those which apply)*

- Loss of appetite or decrease
- Over eating
- Bingeing on food
- Stomach problems
- Headaches
- Purging food (vomiting, using laxatives)

### **Chronic (long standing) difficulties with:**

*(check those which apply)*

- Focusing
- Staying on task
- Being organized
- Completing tasks
- Academic/work performance

Place patient label here

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History Form (Age 18+)  
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BH Clinic Note

## ADULT REGISTRATION INFORMATION

### Patient Information:

Date: \_\_\_\_\_

First, Middle, Last Name: \_\_\_\_\_ Preferred: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Gender: \_\_\_\_\_ Gender Assigned at Birth: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

### SPOUSE/PARTNER

Spouse/Partner Name: \_\_\_\_\_ Preferred: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

### EMERGENCY CONTACT - OTHER THAN SPOUSE/PARTNER

CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone number: \_\_\_\_\_ Work phone number: \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION

INSURANCE NAME: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female

**IF DIFFERENT THEN PATIENT** - Relationship: \_\_\_\_\_ Name on card: \_\_\_\_\_

MEMBER ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

MEDICAL CLAIMS ADDRESS: \_\_\_\_\_

## 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 read and understand the above. Client/Guardian initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient Identification:

PeaceHealth Medical Group      SYS1114-OR (03/25/20)

**Patient/Client Provider Responsibility Disclaimer - OR**  
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Consents

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.

Patient Identification:

PeaceHealth Medical Group      SYS1114-OR (03/25/20)

**Patient/Client Provider Responsibility Disclaimer - OR**

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Consents

**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.

Patient Identification:

PeaceHealth Medical Group      SYS1114-OR (03/25/20)

**Patient/Client Provider Responsibility Disclaimer - OR**

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Consents

**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 of Patient/Person Authorized to Sign for Patient      Relationship      Date      Time

\_\_\_\_\_  
Signature of Patient/Person Authorized to Sign for Patient      Relationship      Date      Time

\_\_\_\_\_  
Signature of Patient/Person Authorized to Sign for Patient      Relationship      Date      Time

\_\_\_\_\_  
Signature of Caregiver      EHR User ID      Date      Time

Patient Identification:

PeaceHealth Medical Group      SYS1114-OR (03/25/20)

**Patient/Client Provider Responsibility Disclaimer - OR**  
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Consents

# Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at PeaceHealth.

PeaceHealth provides financial assistance in accordance with state and federal requirements to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. To view PeaceHealth's Financial Assistance Policy and additional information, please visit [peacehealth.org](http://peacehealth.org).

## What does financial assistance cover?

The hospital financial assistance covers appropriate hospital-based services provided by PeaceHealth depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

## If you have questions or need help completing

**this application:** Please contact Customer Service at 877-202-3597. You may obtain help for any reason, including disability and language assistance.

## In order for your application to be processed, you must:

- Provide us information about your family  
Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income
- Attach additional information if needed
- Sign and date the form

## Note: You do not have to provide a Social Security number to apply for financial assistance.

If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

## Mail, email or fax completed application with all documentation to:

PeaceHealth Patient Financial Services, PO Box 748632, Los Angeles, CA 90074-8632. Email: [financialassistance@peacehealth.org](mailto:financialassistance@peacehealth.org)  
Fax: (360) 729-3047. Be sure to keep a copy for yourself.

## To submit your completed application in person:

Please contact Customer Service for the closest drop-off location at 877-202-3597.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

*By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.*

**We want to help. Please submit  
your application promptly!  
You may receive bills until we  
receive your information.**





# PeaceHealth Financial Assistance Application Form - **CONFIDENTIAL**

Please provide answers to each question. If it does not apply, write "NA". Attach additional pages if needed.

**PLEASE MAIL COMPLETED APPLICATION TO PEACEHEALTH, PO BOX 748632, LOS ANGELES, CA 90074-8632**

Guarantor Number \_\_\_\_\_

## SCREENING INFORMATION

- Do you need an interpreter?  Yes  No *If Yes, list preferred language:* \_\_\_\_\_
- Does the patient receive state public assistance services such as Medicaid, TANF, Basic Food, or WIC?? (OPTIONAL)  Yes  No
- Is the patient currently homeless?  Yes  No      Is the patient's medical care need related to a car accident or work injury?  Yes  No

## PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.

## PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name	Patient Last Name
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <i>May Specify:</i> _____	Birth Date	Social Security Number (not required)
Person Responsible For Paying Bill	Relationship To Patient	Birth Date
		<i>Note: You do not have to provide a Social Security number to apply for financial assistance</i>
Mailing Address		Main Contact Number(s)
City	State	Zip Code
		_____) _____ _____) _____
		Email Address: _____

- Employment status of person responsible for paying bill
- Employed** *Date of hire:* \_\_\_\_\_       **Unemployed** *How long unemployed:* \_\_\_\_\_
- Self-Employed**     **Student**       **Disabled**       **Retired**       **Other:** \_\_\_\_\_

## FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE**      *Use additional paper if needed.*

Name	Date of Birth	Relationship to patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total GROSS monthly income (before taxes):	Also applying for financial assistance?

**All adult family members' income must be disclosed and proof included with completed application. Examples of income sources include:**

- Wages ■ Unemployment ■ Self-employment ■ Workers Compensation ■ Disability ■ SSI ■ Child/spousal support ■ Work study programs (students) ■ Pension ■ Retirement account distributions ■ Other *Please explain:*

## ADDITIONAL INFORMATION

Please use additional pages if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

## PATIENT AGREEMENT

- I understand that PeaceHealth may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.
- I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.
- By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

Signature of Person Applying \_\_\_\_\_

Date \_\_\_\_\_

**If you have questions or need help completing this application: Please contact Customer Service at 877-202-3597. You may obtain help for any reason, including disability and language assistance. To view PeaceHealth's Financial Assistance Policy and additional information, please visit [peacehealth.org](http://peacehealth.org).**

**PLEASE MAIL COMPLETED APPLICATION TO PEACEHEALTH, PO BOX 748632, LOS ANGELES, CA 90074-8632**