**KOLPIA COUNSELING**

**607 Siskiyou Blvd, Ashland, OR 97520 P: 541-482-1718 F: 541-482-0964 info@kolpiacounseling.com**

## *Overview of Getting Started at Kolpia*

***Orientation:*** There are many requirements in place for licensed substance use programs like Kolpia. Most of this paperwork and process is handled by our Front Office Manager. However, there are important parts of your orientation that are also done in your first appointment with a counselor. It is our job to inform you of your rights and provide comprehensive care. Thank you for your patience with this process.

***Assessment:*** You will meet with a counselor who will provide a comprehensive assessment for substance use. This may take up to an hour and a half or two hours. This assessment is based on the American Society of Addiction Medicine (ASAM) standards and the Diagnostic Statistical Manual (DSM-5) criteria and will guide your treatment.

***Service Planning:*** *After completing your assessment,* your counselor will discuss with you a recommended level of care. Kolpia offers education, regular outpatient, and intensive outpatient services. Based upon your assessment and discussion on level of care, the counselor will co-create with you a service plan that is designed to help meet your needs and outlines the specific services you agree to attend. If your needs exceed what Kolpia offers, your counselor will work with you to facilitate transfer of care to a program better suited for your current needs.

***Attendance:*** "Showing up" is the first and most important step in treatment. *Attending the services laid out in your service plan is a requirement of treatment.* Patterns of intermittent or infrequent attendance will be addressed with you by your counselor and may result in closure of your treatment episode.

***Mental Health Services:*** If you are requesting mental health services, it follows the same outline as above. After orientation, you will have a comprehensive mental health assessment and service planning. Kolpia provides a collaborative approach to treatment for those clients who need and receive both mental health and substance use services. Mental health services at Kolpia can be provided to those with private health insurance, private pay clients, and some Medicaid clients.

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# Client Profile

Information on this form is held in the strictest confidence and will not be released without your written approval except as allowable or required by law (please see confidentiality policy below). Please fill out this form as thoroughly as possible to help facilitate your enrollment. This form must be signed and dated at the bottom.

**Please Print Legibly**

Full Legal Name:____________________ D.O.B: ________ Age:_____ Gender: ________

Marital Status: Single Married Divorced Legally Separated Widowed Significant Other (circle one)

Mailing Address:____________________ City:__________ State:____ Zip:__________

Street Address:____________________ City:__________ State:____ Zip:__________

Preferred Phone#: ________________(text ▢) Alternate Phone#: ________________(text ▢)

**May we leave a message? Yes No May we email/text appointment reminders? Yes No**

**E-Mail Address:**______________________________

Social Security #:______________ Drivers License #: ________________

Reason for Visit: (i.e. DUI, MIP, Marriage) : ________________________

Referred by: (i.e. Self, Physician, Court, Probation, etc): ________________________

Probation Officer's Name: (if applicable):________________Telephone: ________________

Emergency Contact Name:______________ Emergency Phone Number: ________________

***Please complete a release of information for your emergency contact.***

## Responsible Party/ Financial Information

Name (if different than client):____________________D.O.B. ________________

Employer Name:____________________Employer Phone: ________________

Employer Address: ______________________________

Do you have health insurance? (circle one) Yes or No

Do you want Kolpia Counseling to bill your insurance company? (circle one) Yes or No

***If yes, you will also need to complete a release of information for your insurance company.***

Name of Insurance Company: ______________________________

Subscriber's Name:__________________ Relationship to Client: __________________

Subscriber's DOB:________ ID/Policy #: ____________ Group #: ________________

Primary Care Physician: ______________________________

Date of last Physical Exam: __________________

***If Medicare, will need to complete Advanced Beneficiary Notice (ABN) prior to each service attended***

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered, I have read and understand all of the information on this form and have completed the answers. I certify this Information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information. I authorize Kolpia Counseling Services to bill my insurance company for services rendered, if I choose not to use my insurance, or do not have any, then I will be responsible for payment at time of service. **I also acknowledge that I have been informed that Kolpia may leave a message on my voicemail regarding appointments, billing, and requesting a return call. An automated email reminder is available - ask Office Manager if interested.**

Signature of Client:____________________________ Date: ________________

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# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

| **Name** *(Last, First, M.I.)*: ☐ M ☐ F | **DOB:** |
|---|---|
| **Reason for visit:** | |
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | |
| **Primary Language:** ☐ English ☐ Spanish ☐ Indian (Includes Hindi & Tamil) ☐ Other __ | |
| **Race:** ☐ American Indian/Alaska Native ☐ Asian ☐ Pacific Islander ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other__ ☐ Prefer Not to Answer | |
| **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Answer | |
| **Previous or referring doctor:** | **Date of last physical exam:** |

## PERSONAL HEALTH HISTORY

**Medical History – Please provide a brief explanation for the medical conditions which apply to you.**

| **Condition** | **No** | **Yes** | **Explanation** |
|---|---|---|---|
| Arthritis | | | |
| Asthma | | | |
| Bleeding/Blood Disease | | | |
| Cancer | | | |
| Diabetes | | | |
| Heart Disease/Murmur | | | |
| High Blood Pressure | | | |
| Kidney/Urinary disease | | | |
| Liver problems/Hepatitis | | | |
| Nervous disorders | | | |
| Seizures or Epilepsy | | | |
| Thyroid Disorders | | | |
| Other | | | |

**Date of Last Menstrual Cycle?** **Is there any chance that you may be pregnant?** ☐ Yes ☐ No

**Are you pregnant? If yes, how many months?** **Peri-Menopausal or Menopausal?**

**Surgeries**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**Hospitalizations for other Medical or Psychiatric Issues:**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

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| | | |
|---|---|---|
| | | |

**Family History – Please provide a brief explanation for the medical conditions which apply to your family.**

| **Condition** | **Dad** | **Mom** | **Sibling** | **Child** | **Other** | **Explanation** |
|---|---|---|---|---|---|---|
| Arthritis | | | | | | |
| Asthma | | | | | | |
| Bleeding/Blood Disease | | | | | | |
| Cancer | | | | | | |
| Diabetes | | | | | | |
| Heart Disease/Murmur | | | | | | |
| High Blood Pressure | | | | | | |
| Kidney/Urinary disease | | | | | | |
| Liver problems/Hepatitis | | | | | | |
| Nervous disorders | | | | | | |
| Seizures or Epilepsy | | | | | | |
| Thyroid Disorders | | | | | | |
| Other | | | | | | |

**Currently, do you have any of the following symptoms? (Please mark those that apply)**

| | | | | | |
|---|---|---|---|---|---|
| | Seasonal allergies | | Ringing in the ear(s) | | Snoring |
| | Cough | | Hearing loss | | Nosebleed |
| | Shortness of breath | | Dizziness | | Problems swallowing |
| | Fever | | Facial pain | | Heartburn or indigestion |
| | Weight loss or Weight Gain (circle) | | Nasal congestion | | Swollen glands |
| | Rash on skin | | Nasal drainage | | Bruise or bleed easily |
| | Temperature intolerance | | Sore throat | | Muscle or joint pain |
| | Ear pain | | Hoarseness | | Headache |
| | Ear drainage | | Lumps or nodules (where?) | | Numbness/Weakness |
| | Ear blockage | | Excessive daytime tiredness | | Visual disturbances |

| **Allergies to medications or other toxins?** | ◻ Yes | ◻ No |
|---|---|---|
| Name of Drug/Allergy | Describe Reaction | |
| | | |
| | | |
| | | |

**List your Medications (including prescribed drugs and over-the-counter drugs, such as vitamins, supplements and inhalers)**

| Name the Drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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## HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

| | | | | | |
|---|---|---|---|---|---|
| **Exercise** | ☐ Sedentary (No exercise) | | | | |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | |
| | ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | |
| | ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | |
| **Diet** | Are you dieting? | | | ☐ Yes | ☐ No |
| | If yes, are you on a physician prescribed medical diet? | | | ☐ Yes | ☐ No |
| | # of meals you eat in an average day? | | | | |
| | Rank salt intake | ☐ Hi | ☐ Med | ☐ Low | |
| | Rank fat intake | ☐ Hi | ☐ Med | ☐ Low | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | |
| | # of cups/cans per day? | | | | |
| **Alcohol & Other Drugs (Not Prescribed Unless Medical Marijuana)** | Do you drink alcohol ? | | | ☐ Yes | ☐ No |
| | If yes, what kind? | | | | |
| | How many drinks per week? | | | | |
| | Are you concerned about the amount you drink? | | | ☐ Yes | ☐ No |
| | Have you considered stopping? | | | ☐ Yes | ☐ No |
| | Have you ever experienced blackouts? | | | ☐ Yes | ☐ No |
| | Are you prone to "binge" drinking? | | | ☐ Yes | ☐ No |
| | Do you drive after drinking? | | | ☐ Yes | ☐ No |
| | Do you currently use recreational or street drugs? | | | ☐ Yes | ☐ No |
| | If yes, what kind? If yes, what kind? If yes, what kind? If yes, what kind? | | | | |
| | Method of Use (i.e., smoke, pills, snorting, etc.)? How many drinks per week? How many drinks per week? How many drinks per week? How many drinks per week? | | | | |
| | Amount per day/week and what quantity? | | | | |
| | Have you ever given yourself ANY drugs with a needle (not including insulin)? | | | ☐ Yes | ☐ No |
| **Tobacco** | Do you use tobacco? | | | ☐ Yes | ☐ No |
| | ☐ Cigarettes – pks./day | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day | |
| | ☐ # of years | ☐ Or year quit | | | |
| **Personal Safety** | Do you live alone? | | | ☐ Yes | ☐ No |
| | Do you have frequent falls? | | | ☐ Yes | ☐ No |
| | Do you have vision or hearing loss? | | | ☐ Yes | ☐ No |
| | Do you have an Advance Directive or Living Will? | | | ☐ Yes | ☐ No |
| | Would you like information on the preparation of these? | | | ☐ Yes | ☐ No |
| | Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | | | ☐ Yes | ☐ No |

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# Prescriptions

Are you currently taking any prescription medications? NO YES

If yes, we are required to get copies of your prescriptions from you.

## Why do I need to Get Copies of My Prescriptions?

- Oregon law requires that agencies that are licensed to provide substance use treatment services must have copies of any active prescriptions that a client is on.

## How do I Get Copies of My Prescriptions?

- Here are your choices:

1. Your pharmacy may have its own process. It is best if you call and ask directly.
2. Fill out a Release of Information Authorization form at Kolpia for your Pharmacy to fax to us a list of your active prescriptions.
3. When you go to your pharmacy ask them to provide it to you and bring it to us at your next appointment.

**Please inform the Office staff completing your orientation on your preference for how to obtain copies of your prescriptions.**

**Thank you!!!!**

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# OUTPATIENT SERVICES FEE AGREEMENT

I, ______________________________________ have chosen to participate in outpatient counseling either voluntarily or in order to comply with mandates. I agree to attend all scheduled sessions and pay all fees at the time of service. I understand there is a $40 no show fee* if I miss a scheduled appointment without at least 1 full business day notice, and that if I have cancelled or missed more than one appointment without sufficient notification I will be removed from the schedule with any no show fees due before I can make my next appointment. Excessive no shows or cancellations may also result in being discharged from the program. Further, I understand that any outstanding fees for treatment programs (to be in compliance with DUII mandate) MUST BE PAID IN FULL before Kolpia Counseling Services will issue a Completion Certificate or provide status update indicating treatment has been completed.

**Does not apply to Medicaid clients*

***Kolpia Counseling Services accepts OHP and other insurance providers. For those wanting to use INSURANCE for:***

- **Substance Abuse Treatment:** We accept private health insurances (call 541-482-1718 to inquire about specific plans), Medicaid, and private pay.
- **Mental Health Counseling:** We accept private health insurances (call 541-482-1718 to inquire about specific plans), some Medicaid, and private pay.

## SERVICES

Kolpia Counseling Services offers three levels of care for substance use treatment: A&D Education, Outpatient, and Intensive Outpatient. Each individual will be placed in a level of care depending upon the outcome of their ASAM Assessment.

The following are estimated levels of care with an average length of stay, and an average array of services that one can expect when enrolling in treatment at Kolpia Counseling. If you have difficulty in maintaining sobriety or achieving solid recovery, the counselor will discuss with you a change in level of care.

Cost of care is dependent upon the level of care you are placed at, frequency, and length of care. The following is provided to help you ***estimate*** cost of services.

**LEVEL 0.5 -- EDUCATION (Usually for DUII Education or Possession Charges)**

- Assessment consistent with ASAM standards
- Minimum of 90 days clean and sober immediately preceding completion (as evidenced by clean UAs)
- 6+ UAs
- 8 Weeks of A&D Education Classes
- 3 Individual Counseling Sessions
- Recommended 3 – 12 Step or Community Recovery Support Meetings

**LEVEL 1.0 -- OUTPATIENT (OP)**

- Assessment consistent with ASAM standards
- Minimum of 90 days clean and sober immediately preceding completion (as evidenced by clean UAs)
- 8+ UAs
- 12 Weeks of A&D Education Classes
- 1 additional therapeutic group (weekly)
- 1 IRG Group (weekly)
- 6 Individual Counseling Sessions
- Recommended 6 – 12 Step or Community Recovery Support Meetings

**LEVEL 2.0 -- INTENSIVE OUTPATIENT PROGRAM (IOP)**

- Assessment consistent with ASAM standards
- Minimum of 90 days clean and sober immediately preceding completion (as evidenced by clean UAs)
- 12+ UAs
- 12 Weeks of IOP – 3 to 4 mornings a week, from 9 – 12:15 daily
- 12 Individual Counseling Sessions
- Recommended 8 – 12 Step or Community Recovery Support Meetings
- Prior to conclusion of IOP, recommended transition planning to Outpatient level of care for a minimum of 30 days.

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**PLEASE INITIAL RATES WITH KOLPIA STAFF**

1. Initial Assessment $240 ________
2. Service Planning $180 ________
3. Individual Therapy – 1⁄2 hr appointment $120 ________
4. Individual Therapy – 1 hr appointment $180 ________
5. Individual Therapy – 1 1⁄2 hr appointment $300 ________
6. Group Therapy $ 65 ________
7. IOP Group (Daily) $120 ________
8. Drug Screen (UA) $ 60 ________

**ADDITIONAL TERMS:**

➢ Payment is due at the time of service (this includes co-payments), with the exception of Drug Screen (random UA) charges, which may be paid at time of service or billed via monthly statement.

➢ Balances must be paid in full prior to receiving DUII or Court Completion Certificates/ODL Certificates.

➢ Clients are responsible for their remaining insurance balances (copays, deductibles, and all co-insurances).

➢ If you are experiencing a financial hardship that may prevent you from being able to attend treatment, please discuss with your counselor.

**Outstanding Payments:**

At times, clients leave treatment against clinical advice; in these instances, if payments are not received when services are rendered, a monthly invoice will be provided to the client or his/her fiscally responsible person. Invoice payments are due upon receipt. Any unpaid or outstanding fees (such as copayments) will be added to any other financial responsibilities that you may have on account with Kolpia Counseling Services; obligations for payment carry the same legal expectations thereof. An itemized report will be sent monthly, so you will be aware of what you owe.

Clients with a balance on their account that has not been paid in full within 14 days will not be allowed to attend any groups or individual sessions, *unless a payment plan has been arranged with management*. For those clients who have been mandated to treatment, if your balance hasn't been paid within 30 days of completing all treatment services, your term at Kolpia will be considered "Incomplete" (thus a Certificate of Completion will not be issued). Due to the legal requirement that Kolpia must be able to document 90 days continuous sobriety (via clean UAs) as a condition of your probation/parole – individuals may be required to complete an additional 90 days of services.

**SIGNED Fee Agreement:**

I, ___________________________________, had the opportunity to ask questions and acknowledge that I completely understand the Terms & Conditions outlined above. By signing below I agree to fulfill my fiscal and personal responsibilities as a recipient of the services provided by Kolpia Counseling Services.

___________________________________ ______________________________ DATE __________________

(Client's Printed Name or Legal Guardian) (Client's Signature)

___________________________________ ______________________________ DATE___________________

(Kolpia Counseling Staff's Printed Name/Credentials) (Staff's Signature)

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# Informed Consent (1 of 2)

GUIDING PHILOSOPHY: At Kolpia we operate from a place of hope and experience, knowing that every person has the ability to grow and heal through the difficulties of life. We use a trauma-informed approach as well a patient-centered philosophy that puts the needs of the patient first. Our services are integrative meaning that we successfully combine a variety of services that are holistic, evidence-based, and enjoyable. We are proud of our programs, counselors, and physicians and hope you enjoy your time with us.

AVAILABLE SERVICES: Kolpia Counseling Services provides a variety of services for the treatment of mental health concerns and substance abuse issues. The programs at Kolpia are patient-centered, integrative, trauma informed and family-involved. The services depend on the client's needs and the treatment plan collaboratively created between the client, the client's primary counselor, and the family members. It will normally include an assessment, individual counseling, group counseling, and may also include family counseling, nutrition, and a variety of integrative recovery groups such as drumming, mind/body therapy, and art therapy among others.

REGARDING TREATMENT: Counseling and therapy are beneficial, but as with any treatment, there are some inherent risks. Assessment and subsequent counseling will involve discussion about personal issues and
may bring to the surface uncomfortable emotions for any or all of the individuals involved. The goal of the counselor is to follow the path of truth, however uncomfortable or painful that may be at times. With substance abuse counseling there are frequently specific recommendations indicated that could involve significant lifestyle changes that the client may not want, or agree with; this may be construed as a "risk" associated with treatment. However, the benefits of assessment and counseling often far outweigh the risks. Some of the benefits include improved personal and family relationships, reduced feelings of emotional distress, improved personal performance, reduction of health and safety dangers, and specific problem solving.

ENDING TREATMENT WELL: It is important to end treatment well. This means following through on all appointments and completing the full recommended treatment, including an exit session with referrals and an aftercare plan as appropriate. Stopping in the middle of treatment with no communication or closure (leaving treatment against clinical advice) increases your risk of experiencing adverse effects resulting from incomplete treatment. If you do not show up for a scheduled appointment and the agency has no contact from you within the following five business days, you will no longer be considered a client of Kolpia and will be discharged as a result of having left against clinical advice. Depending on circumstances, you may be able to re-engage in services at a later time when you are more prepared to fully and meaningfully participate in your treatment.

CONFIDENTIALITY: In accordance with HIPAA and 42 CFR a client's disclosure, correspondence, and private medical records are confidential and will never be shared with any other person, organization, or agency without express consent from the client, parent, or guardian. For more information about abuse reporting, you may request a copy of our provider policies. All communication between you and your therapist becomes a part of the clinical record. This record is accessible to you at your written request. Your counselor or physician will keep confidential all conversations regarding assessment and treatment with the following exceptions: a) you authorize your therapist to disclose information to a particular party such as a medical doctor or prescriber; b) your therapist determines that you are a threat to yourself or to others; c) you disclose that harm has been done to a child or dependent adult; d) the court has ordered information to be disclosed e) medical emergency. See *Patient Confidentiality Policy.*

Pg 1 of 2 Initials: ________

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# Informed Consent (2 of 2)

TRAINING FACILITY: As a respected and experienced provider of counseling services in the community, Kolpia participates in the training of new professionals in both substance use and mental health counseling. All counselors-in-training receive extensive supervision provided by credentialed clinical supervisors. Counselors-in-training may observe and deliver services. All services delivered by a counselor-in-training will be within the scope of their current level of training and experience.

CLIENT RIGHTS, GRIEVANCES AND APPEALS: You have the right to refuse or modify any therapeutic technique or direction that you feel may not best serve your needs. You have the right to discuss positive and negative effects of counseling with your counselor. You have the right to be treated in a professional and ethical manner. If you are dissatisfied for any reason, please discuss your concerns with your primary counselor. If you feel your are unable to resolve an issue, or that your counselor has performed in an unethical manner, you may report your complaint directly to the clinical supervisor or director. The complete documents regarding patient confidentiality, individual rights, and grievances and appeals are included in this packet and will be discussed with you today. By signing this form you acknowledge you have received these documents and they have been discussed with you by your counselor / provider.

CLIENT/THERAPIST RELATIONSHIP: You and your counselor have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your counselor can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service. It is not appropriate to try to contact your counselor by personal phone, email, personal mail, or social media such as Facebook and Twitter, nor is it appropriate for your counselor to attempt to establish a personal relationship with you by these means.

APPOINTMENTS: Regular counseling sessions range between 60-120 minutes for an initial assessment and 30-60 minutes long for follow up appointments. Extended sessions may be scheduled for conjoint session with family members. Group durations range from 60-120 minutes. Please arrive on time and with the necessary materials for treatment. Individual appointments where the client is 10 or more minutes late may be cancelled and rescheduled. If client arrives late for an individual appointment and is able to be seen at that time, the appointment will still end at the originally scheduled time and client is responsible for the regular fees associated with original appointment length. Clients will not be able to join a group in progress beyond the first 5 minutes of the scheduled group.

TERMINATING TREATMENT: You have the right to terminate or take a break from your treatment at any time without the counselor's permission or agreement. However, if you do decide to exercise this option, you are encouraged to talk with your counselor about the reason for your decision in a counseling session so that sufficient closure can be achieved. During the final session appropriate referrals can be made. By your signature below you are indicating that you have read and understand this agreement and that you are willing to undergo mental health, substance abuse/dependence, integrative treatment by Kolpia Counseling Services. By this signature you also agree to hold harmless Kolpia Counseling Services or any employee or contractor of the agency for any undesired mental, physical, or emotional effects if is it is found the employee or contractor was acting and in accordance with best practices and legal guidelines outlined by state, federal, and professional organizations.

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Client/parent printed name Signature Date

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# Individual Rights:

In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:

1. Choose from available services and supports, those that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence;
2. Be treated with dignity and respect;
3. Participate in the development of a written Service Plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written Service Plan;
4. Have all services explained, including expected outcomes and possible risks;
5. Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.
6. Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:
    a. Under age 18 and lawfully married;
    b. Age 16 or older and legally emancipated by the court; or
    c. Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs;
7. Inspect their Service Record in accordance with ORS 179.505;
8. Refuse participation in experimentation;
9. Receive medication specific to the individual's diagnosed clinical needs; including medications used to treat opioid dependence;
10. Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
11. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
12. Have religious freedom;
13. Be free from seclusion and restraint;
14. Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;
15. Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented;
16. Have family and guardian involvement in service planning and delivery;
17. Make a declaration for mental health treatment, when legally an adult;
18. File grievances, including appealing decisions resulting from the grievance; See grievance policy and procedures.
19. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
20. Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
21. Exercise all rights described in this rule without any form of reprisal or punishment.
22. Notification of Rights: The provider must give to the individual and, if appropriate, the guardian, a document that describes the applicable individual's rights as follows:
23. Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;
24. The rights, and how to exercise them, must be explained to the individual, and if appropriate, to her or his guardian; and
25. Individual rights must be posted in writing in a common area.

______________________________________________________________________________

Client/parent printed name Signature Date

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# Patient Confidentiality and HIPAA

In accordance with HIPAA, 42 CFR part 2, and ORS 179.505 and 192.518 and 192.530, all patient information is to be protected. This includes:

1. Obtaining informed consent to procure verbal or written medical history and provide treatment.
2. Obtaining written consent to obtain information from another medical provider or agency regarding a client or patient.
3. Obtaining written consent in the form of a release of information (ROI) to share information with another medical provider, agency or family member. The ROI must:
    a. identify each agency or individual we wish to share the information with, or who wishes to share information with us, b. identify the specific information that is to be shared, c. designate a specific period of time for the sharing of information, d. be corrected in the case of errors by placing one line through the error and initialing the correction.
4. A release of information (ROI) form is necessary when reporting any information to referral source including presence in treatment. Clients have the legal right to engage in or continue in services without an ROI for their referent. When a referent is paying for the treatment, the client may be required by that contract to either keep the ROI in place or pay for any services when an ROI is not valid.
5. In the case of an emergency or urgent care the practitioner is able to share PHI with medical providers in accordance with 42 CFR part II.
6. In the case of collaborative care with another practitioner, provider or prescriber PHI can be shared with the client's consent and a ROI that identifies the specific collaborative care provider that information is to be shared with.
7. It is important to not re-share protected PHI. For example if we receive PHI from a primary care provider, and we are referring a patient for hospitalization, we can only provide the PHI we have generated in our assessments and service delivery and cannot share the the information that was shared with us from the primary care provider.
8. Written and signed consent must be granted by a parent or guardian if the client is 13 years of age or younger. It is important to check the informed consent form to ensure the document has been signed by the parent/guardian in addition to or in lieu of the child.
9. No client or patient information is to be shared between providers or anyone else using unsecured email programs. Patient information should only be shared using the secured platform within the electronic medical records program provided by the agency.
10. Client contact outside of the agency: To maintain the anonymity of the client as well as to discourage inappropriate relations between clients and employees of the agency it is important that our conduct with them outside of the agency is professional. Contact should be avoided when possible and intentionally limited to short and cordial interactions if it is not possible to avoid contact. All conversation regarding the agency, programs and especially any private information related to that client or any other client is strictly not allowed. If this policy is breached by an employee they will be counseled appropriately which may include immediate termination.
11. In accordance with 42 CFR part II there are express exceptions to the Confidentiality Agreement in the following circumstances:
    a. When emergency or urgent care are necessary.
    b. When mandatory abuse reporting conditions apply (see Mandatory Abuse Reporting).
    c. When a crisis situation has occurred at the agency that includes a threat to the safety and security of the client, the employees and other persons on agency property.
    d. When a client has indicated a desire to cause harm to themselves or another person.
    e. When criminal activity has occurred at the agency or witnessed by an employee of the agency.
    f. Communicating with other agencies, organizations, providers or prescribers is necessary for collaboration and continuity of care. The client will be asked sign an ROI to support their overall treatment goals.
    g. When required by the criminal justice system to share information by mandate or subpoena.
    h. When a client is mandated for treatment and the client's referent must be contacted regarding non-compliance with program requirements, positive UDS results, failure to provide UDS samples and uncomplete program requirements.

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Client/parent printed name | Signature | Date

**KOLPIA COUNSELING**

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# Grievances and Appeals

1. Any individual receiving services, or the parent or guardian of the individual receiving services, may file a grievance with the agency, the individual's managed care plan or the Division. The contact information for these agencies is listed at the end of this document.
2. A counselor or other agency employee will review a written copy of the agency's grievance procedures with the individual receiving services, the parent or guardian upon entry to the program.
3. A copy of the grievance and appeals procedure will be made available at the front desk as well as posted in a conspicuous place in the common area / waiting room. The counselor will show all new clients where to access additional copies of this document.
4. Grievance and Appeals Procedures. (For individuals whose services are funded by Medicaid, grievance and appeal procedures are outlined in OAR 410-141-0260 through 410-141-0266):
    a. It is our practice to attempt to resolve any dispute or grievance at the lowest level starting with the counselor, office manager, direct supervisor, clinical supervisor and director.
    b. Obtain a grievance form by asking the counselor directly or getting one from the front desk or from the policy tree posted in the common area.
    c. Write in detail the complaint, grievance or appeal including pertinent dates and persons involved.
    d. Turn the grievance into the front desk or the counselor.
    e. Once the form has been received the agency has 30 days to conduct any investigation necessary. A timeline follows:
        i. The next business day: The form is to be given to the appropriate program manager depending on what program the client is enrolled in. If there is a conflict of interest the form is to be given to the clinical director or executive director.
        ii. The manager or director will contact the client, parent or guardian within 24hrs to confirm receipt of the form.
        iii. Documentation will be made in the client's chart of the receipt of the form and the initial contact by the manager or director responsible for processing the complaint.
        iv. The manager or director will then consult with all parties involved and conduct the investigation.
        v. Once the investigation has finished, the manager or director will issue a determination no later than 30 days after the beginning of the investigation.
        vi. The client, parent or guardian will be contacted by the next business day once the determination has been made.
        vii. The client, parent or guardian may appeal the determination following the same procedures if they disagree with the determination or have novel information regarding the initial complaint.
        viii. For grievances or complaints regarding abuse they are to follow the abuse protocols.
5. Expedited Grievances: In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in these rules are completed, the individual, or guardian of the individual, may request an expedited review. The program administrator must review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process.
6. Retaliation: A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action.
7. Immunity: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.
8. Appeals: Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:
    a. If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the CMHP Director in the county where the provider is located or to the Division as applicable;
    b. If requested, program staff must be available to assist the individual;
    c. The CMHP Director or Division, must provide a written response within ten working days of the receipt of the appeal; and
    d. If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten working days of the date of the written response to the CMHP Director or Division.
9. Contacts: A person filing a grievance may contact any of the following agencies directly at any time.
    a. Department of Human Services: (541) 482-2041 b.JCHHS (Jackson County Health and Human Services): (541) 774-8200
    c. Disability Rights Oregon: (503) 243-2081 d. Jackson Care Connect: (855)-722-8208 e. AllCare: (541) 471-4106

Client/parent printed name | Signature | Date

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# Orientation Checklist
# Community Resource Needs

Do you currently need access to:

1. Food or Food Stamps **Y or N**
2. Safe housing **Y or N**
3. Transportation **Y or N**
4. Health Care **Y or N**
5. Resources for acute mental health crises **Y or N**
6. Childcare / parenting resources **Y or N**
7. Job training and employment **Y or N**
8. Education and GED information **Y or N**
9. Support groups: **Y or N**
10. Information on 12-Step groups **Y or N**

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# Orientation Checklist

**PLEASE INITIAL WITH KOLPIA STAFF**
**AFTER REVIEW AND ADDRESSING QUESTIONS**

NAME: ______________________________ DATE: ______________

| | | CLIENT INITIALS | STAFF INITIALS |
|---|---|---|---|
| *OFFICE MANAGER* | | | |
| Fee Agreement | | _______ | _______ |
| DUII Agreement | Not Applicable | _______ | _______ |
| No ADES Agreement | Not Applicable | _______ | _______ |
| Required copy of any active prescriptions | | _______ | _______ |
| Informed Consent - Please take your copy home | | _______ | _______ |
| Individual Rights -Please take your copy home | | _______ | _______ |
| Patient Confidentiality- Please take your copy home | | _______ | _______ |
| Grievances and appeals-Please take your copy home | | _______ | _______ |
| Would you like an opportunity to Register to Vote? | YES NO | _______ | _______ |
| *COUNSELOR* | | | |
| Tour | | _______ | _______ |
| Infectious Disease Risk | | _______ | _______ |
| Health History Form | | _______ | _______ |
| Community Resource Needs | | _______ | _______ |
| Do you want a Declaration for Mental Health Treatment? | YES NO | _______ | _______ |
| Program Overview | | | |
| Services- Groups, Individual Sessions (DUII) | | _______ | _______ |
| Assessment, Service Plan, Review- Attendance | | _______ | _______ |
| Groups | | _______ | _______ |
| Urinalysis Drug Screening Tests | | _______ | _______ |