Christian Community Placement Center

MHC Intake Packet – Adult

CLIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ County: _____

Home Phone: _____ Okay to leave message? ☐ Yes ☐ No

Cell Phone: _____ Okay to leave message? ☐ Yes ☐ No

Work Phone: _____ Okay to leave message? ☐ Yes ☐ No

May we call for appointment reminders? ☐ Yes ☐ No

Employer or School: _____ Highest Grade Completed: _____

Occupation: _____ ☐Full-time ☐Part-time ☐Student ☐Non-employed

Gender: ☐Male ☐Female ☐ Other: _____ Ethnicity: _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Living as Married

Maiden Name: _____ Number of Dependents: _____

Have you served in the Military? ☐ Yes ☐ No If 'Yes', which branch? _____

Emergency Contact: _____

Address (if different): _____

City/State/Zip: _____

Home Phone: _____ Cell phone: _____

How were you referred to CCPC? _____

INSURANCE INFORMATION

ARE YOU COVERED BY INSURANCE? ☐ Yes ☐ No (If 'No', skip to next section)

Primary Insurance: ☐Medicaid ☐ Oregon Health Plan ☐ Private Group Health Plan ☐ Other

Insurance Company: _____ Phone: _____

Address: _____ City/State/Zip: _____

Plan Name: _____ Policy #: _____ Group #: _____

ARE YOU COVERED BY MORE THAN ONE INSURANCE PROVIDER? ☐ Yes ☐ No (If 'No', skip to next section)

Secondary Insurance: ☐Medicaid ☐ Oregon Health Plan ☐ Private Group Health Plan ☐ Other

Insurance Company: _____ Phone: _____

Address: _____ City/State/Zip: _____

Plan Name: _____ Policy #: _____ Group #: _____

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MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

PCP Clinic Name: _____

Address: _____

Have you seen your PCP within the last year? ☐ Yes ☐ No

If yes: ☐Routine Visit ☐Other (please explain): _____

Do you have any allergies? ☐ Yes ☐ No

If yes, what allergies and what medications are taken? _____

	YES	NO		YES	NO
Accidents / Major Injuries (car, bike, sports, etc.)			Hospitalizations / ER visits (non-psychiatric)		
Allergies / Hay Fever			Ever been pregnant / suspected pregnant		
Asthma / Lung Problems			Recurring infections		
Chronic Illness / Disease (Diabetes, hepatitis, etc.)			Seizures / Epilepsy		
Headaches			Surgeries		
Head injuries / trauma			Vision Problems		
Hearing Problems			Other (please specify)		

Please explain items checked 'Yes': _____

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MEDICAL INFORMATION, CONTINUED

Pharmacy: _____ Phone: _____

Address: _____ City/State/Zip: _____

CURRENT MEDICATIONS

Name of Medication	Dosage	How long taken?	For What?	Prescriber

Do you currently/have you ever used tobacco (any form)? ☐Current ☐Past ☐ No

If current, how often? _____ How much? _____

Do you currently/have you ever regularly used alcohol? ☐Current ☐Past ☐ No

If current, how often? _____ How much? _____

Do you currently/have you ever regularly used marijuana? ☐Current ☐Past ☐ No

If current, how often? _____ How much? _____

Do you currently use/have you ever experimented with using recreational drugs? ☐Current ☐Past ☐ No

☐ Hallucinogens ☐ Heroin ☐ Inhalants ☐ Methamphetamines ☐ Prescription Opiates ☐ Other: _____

Do you currently/have you ever regularly gambled? ☐Current ☐Past ☐ No

If current, how often? _____

If any are current, has your use of substances or gambling created a problem for you at:

☐Home ☐School ☐Personal Relationships ☐ No

If so, please explain further: _____

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MENTAL HEALTH INFORMATION

What is the primary reason for seeking counseling? Circle as many as apply:

Anger Anxiety Depression Grief/Loss Self-Harm Trauma

Other (please specify): _____

Briefly describe your reason for seeking counseling:

_____

_____

_____

_____

_____

_____

_____

Do you have any history of abuse? ☐ Yes ☐ No

If yes, which type(s): ☐ Sexual ☐ Physical ☐ Verbal ☐ Domestic Violence

If yes, was the abuse as a: ☐ Victim ☐ Perpetrator ☐ Witness

Other issues: ☐ Neglect ☐ Inadequate Nutrition ☐ Other (please specify): _____

_____

_____

_____

Have you ever been in counseling before? ☐ Yes ☐ No

If yes, how long were you in counseling? _____

What was the outcome of your counseling experience? _____

_____

Have you ever had a psychological evaluation? ☐ Yes ☐ No

If yes, with whom? _____

Have you ever been prescribed any psychiatric medication(s)? ☐ Yes ☐ No

If yes, what medication(s)? _____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, please describe the reason and duration: _____

_____

_____

Christian Community Placement Center

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MENTAL HEALTH INFORMATION, CONTINUED

Did your mother have any complications during pregnancy or delivery? ☐ Yes ☐ No

If yes, please describe: _____

Were there any delays/issues meeting developmental milestones (walking, talking, toilet training, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

Do you have a history or current issue with speech development? ☐ Yes ☐ No

If yes, please describe: _____

Are there special, unusual, or traumatic circumstances that affected your development? ☐ Yes ☐ No

If yes, please describe: _____

Briefly describe your temperament and strengths: _____

Briefly describe your relationship with your parents: _____

Briefly describe your relationship with your siblings: _____

Do you have any family members with mental health issues? _____

Additional information related to your childhood development: _____

Christian Community Placement Center

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SYMPTOM CHECKLIST

Please check any symptoms that you have experienced in the past year:

☐ Sleep Problems	☐ Suicidal thoughts	☐ Hallucinations
☐ Too much	☐ Plans	☐ Thoughts or experiences seem strange or odd
☐ Difficulty getting to sleep	☐ Attempts	☐ Intrusive / unwanted thoughts
☐ Frequent waking	☐ Agitated / restless	☐ Flashbacks / trauma easily triggered by other events
☐ Waking, unable to get back to sleep	☐ Extreme irritability	☐ Excessive energy / activity level
☐ Feeling no need for sleep	☐ Easily distracted / difficulty finishing tasks	☐ Problems beginning or keeping relationships
☐ Nightmares	☐ Excessive worry / fear	☐ Extremely elevated mood
☐ Difficulty concentrating / thinking / decision making	☐ Panic attacks	☐ Memory problems
☐ Easily angered / angry / outbursts	Frequency:	☐ Remembering last day or two
☐ Depressed mood	☐ "On edge" or easily startled	☐ Remembering distant past
☐ No interest / pleasure in activities	☐ High anxiety	☐ Loss of time
☐ Feeling fatigue / loss of energy	☐ Racing thoughts	☐ Change in eating habits:
☐ Feelings of worthlessness	☐ Sudden onset of dizziness	☐ Bingeing
☐ Feelings of extreme guilt	☐ Sudden numbness in fingers and toes	☐ Purging
☐ Feelings of emotional numbness / detachment	☐ Homicidal thoughts	☐ Excessive exercise
☐ Isolated / withdrawn	☐ Recurrent / persistent disturbing thoughts	☐ Excessive dieting / fasting
☐ Self-harm	☐ Repetitive or compulsive behavior	☐ Pica (eating non-food items such as soap, dirt, chalk, etc.)

Please describe any other symptoms you have been experiencing: _____

_____

_____

_____

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Welcome

We at Christian Community Placement Center welcome this opportunity to assist you in your desire to resolve your problems through counseling. You will be encouraged to clarify your options and make choices that will increase your personal satisfaction and enhance your physical, mental, and emotional health.

Appointments

Appointments will be scheduled with the business office and usually last 50 minutes for counseling. Please be approximately 15 minutes early for the initial appointment to fill out paperwork, and please bring any insurance information at that time, including ID and group numbers. Due to our therapist's busy schedules, If you are more than 15 minutes late for your appointment we will be unable to see you and you will then need to reschedule for another appointment time.

You are responsible for the payment of all charges incurred. Our policy is that we request payment at the time of the session. We are happy to assist you by billing your insurance company on your behalf. You will receive a monthly statement of your account, and prompt payment of any outstanding balance is requested.*****

Cancellations

Cancellations require a full 24-hour notification so that we have an opportunity to reschedule that time slot. If three (3) scheduled appointments are missed without 24 hour notice, Christian Community Placement Center reserves the right to terminate services. Please ask if you have questions regarding this policy, as we do enforce it.

Leaving Messages by Phone

Office hours are 9am to 5pm, Monday through Thursday and 9am to 2pm on Fridays. Our answering machine operates 24 hours a day, so you can leave a message at night, on weekends or holidays, or even during the workday should we be unavailable to answer the phone.

Emergency Contacts

In the event of a life-threatening emergency, please call 911

Or

Christian Community Placement Center's on-call number during after-hours: (503) 507-7183

Please call the office number during normal business hours.

Christian Community Placement Center (503) 588-5647

Other emergency numbers

Psychiatric Crisis Center	503-585-4949
Northwest Human Services 24-hour crisis hotline	503-581-5535
Marion County Drug Treatment	503-588-5358
Harmony House Detox Center	503-399-5597
Marion County Children's Crisis Center	503-585-4909
Women's Crisis Center	503-399-7722

Christian Community Placement Center

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Risks vs. Benefits

As in anything new, there are inherent risks in a treatment relationship. Due to the intense nature of self-evaluation and awareness, clients typically experience a range of emotions coupled with periods of imbalance. These periods lend themselves to states of confusion and disorganization. However, as in any growth process, the ups and downs usually balance out. If you choose not to seek treatment or outside assistance, you may find that doing nothing results in no change of your condition or behavior.

Consent to Treatment

I have requested treatment from Christian Community Placement Center (CCPC). I understand that testing, diagnostic procedures, and therapy are determined and administered through profession judgments made by CCPC Staff. This treatment may include individual and/or group therapy, and may include consultations with CCPC Counselors, Prescribers and other CCPC Staff/outside clinical supervision consultants. I understand that treatment procedures will be developed according to a mutually agreed upon treatment plan between me, my child (if receiving treatment) and the CCPC staff. I also understand that I will be given an explanation of the purpose of any prescribed medication and potential side effects.

I understand that I am free to withdraw from this relationship at any time, and I agree to attend a closing session upon termination of treatment. I also understand that I am free to file a grievance at any time.

Fees*

Counseling fees are:	Initial Session $175.00
60 Minutes $125.00	20 minutes $50.00

Payment of Fees

You are responsible for the payment of all charges incurred. Our policy is that we request payment at the time of the session. We are happy to assist you by billing your insurance company on your behalf. You will receive a monthly statement of your account, and prompt payment of any outstanding balance is requested.*** *Not applicable for OHP**

PCP Communication

You or your child has enrolled in services with CCPC. As part of your treatment, Oregon law mandates that we communicate with your Primary Care Physician to coordinate your behavioral, physical, and mental health needs. You do not need to sign any additional releases of information. This communication will continue throughout the course of your treatment here. Shared information will include, but is not limited to:

- Prescribed medications
- Significant changes in medications or treatment approach
- Diagnosis and HIV status
- Termination of service

Christian Community Placement Center

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Individual's Rights

CCPC supports and protects the fundamental human, civil, constitutional and statutory rights of each individual. Every individual will be treated with dignity, hope and respect. Our agency provides each individual with a copy of his or her rights.

The following is a list of Individual's Rights:

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;
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;

Individual's Rights, continued:

17. Make a declaration for mental health treatment, when legally an adult;
    File grievances, including appealing decisions resulting from the grievance;
18. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
19. Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
20. Exercise all rights described in this rule without any form of reprisal or punishment.

Oregon Health Plan and Mid-Valley Behavioral Health Plan clients have additional rights and responsibilities that are posted and available in a handout. Upon request, CCPC can offer this form in alternative formats or languages.

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CCPC's Individual Client Guidelines

As in anything new, there are inherent risks in a treatment relationship. Due to the intense nature of self-evaluation and awareness, clients typically experience a range of emotions coupled with periods of imbalance. These periods lend themselves to states of confusion and disorganization. However, as in any growth process, the ups and downs usually balance out.

If you choose not to seek treatment or outside assistance, you may find that doing nothing results in no change of your condition or behavior.

You deserve to have a healthier, happier, more functional life. You will gain the maximum benefit from our program if you are open, honest, and willingly participate in individual and group therapy.

Here are some hints for successful individual and group sessions:

- ✧ Stay open to the process
- ✧ Be aware of what you are feeling
- ✧ Share your feelings with your therapist or group members
- ✧ Complete journal and writing assignments; denial has a difficult time surviving in writing
- ✧ Ask questions (there are no dumb questions)
- ✧ Have courage to change

Individual's Grievance Procedure

1. Any complain/grievance which is not mutually resolved between individuals or between individuals and staff shall be communicated to any staff member of Christian Community Placement Center either in writing or orally so that it can be reduced to a clear, concise written report. This will be give to the Executive Director to be logged in the Complaints Log.
2. In response to receipt of such written complaints/grievances, the Executive Director shall immediately investigate and will try to complete the process in 5 working days. If more time is needed, the individual will be notified in writing. We will inform the individual of reason why and how much more time is needed to resolve the issues. The longest about of time for the complaint to process is 30 calendar days following receipt. This will be recorded in the Complaint Log and a file will be kept of all complaints received for 2 years.

For MVBCN Individuals: Please refer to the handout "Our Process for Complaints and Feedback" that is available in the lobby, from the receptionist, or at www.mvbcn.org.

Effective Date: February 1st, 2015

Revised 8/24/2017

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please consult your Therapist.

Christian Community Placement Center
Email: receptionist@ccpcusa.com
4890 32nd Ave. SE, Salem OR 97317
(503) 588-5647

WHO IS SUBJECT TO THIS NOTICE:

This notice describes the privacy practices of **Christian Community Placement Center (CCPC)** and the social workers, therapists, counselors, nurses and other individuals and staff that work at **Christian Community Placement Center**.

YOUR HEALTH INFORMATION:

This notice applies to the information and records we have about your health, health status, and the care and service you receive from CCPC. Your health information may include information created and received by CCPC, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

Uses and Disclosures with Your Consent

Except in an emergency or other special circumstances, we will ask you to read and sign a written consent regarding the uses for and the disclosure of Protected Health Information for purposes of: treatment provided to you, obtaining payment for services provided to you and for our health care operations (e.g., internal administration, quality improvement and customer service) as detailed below:

- Treatment – We may use and disclose Protected Health Information to provide treatment and other services to you. For example, to diagnose and treat your illness or to phone in prescriptions for you.
- Payment – We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, health plan, or a third party. For example, we may need to give your health plan information about a service you've received so your health plan will pay for the service. We may need to disclose information to a collection agency to assist in the collection of a past due account.
- Health Care Operations – We may use and disclose Protected Health Information for our health care operations. They include internal administration and planning and various activities that improve the quality

and cost effectiveness of the care we deliver to you. For example, we may use Protected Health Information to evaluate the quality and competence of our clinical staff and other health care workers.

- Business Associates – We may contract with business associates to perform certain functions or activities on our behalf, such as treatment, payment and health care operations. These business associates must agree to safeguard your Protected Health Information.
- Organized Health Care Arrangement – For Mid-Valley Behavior Care clients, we are a member of the Marion County Integrated Delivery System (IDS) and we may share information as needed among member agencies for the purposes of treatment, payment and health care options.
- Appointment Reminders – We may contact you as a reminder that you have an appointment for treatment or clinical care at Christian Community Placement Center.
- Treatment Alternatives and Related Products and Services – We may tell you about or recommend possible treatment options or alternatives, or related products or services that may be of interest to you.

Please notify us if you do not wish to be contact for appointment reminders, or if you do not wish to receive communications about treatment alternatives or related products and services. If you advise us **in writing** (at the address listed at the top of this notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

Uses and Disclosures of Your Highly Confidential Information – When we are using or disclosing certain Protected Health Information about you that is deemed highly confidential information, we follow special procedures required by federal and Oregon laws Highly Confidential Information includes psychotherapy notes and Protected Health Information about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing; (4) venereal disease(s); (5) genetic testing; (6) child abuse and neglect; and (7) sexual assault. We use and disclose Highly Confidential Information with your knowledge and limited by a particular purpose.

Your Consent only permits us to use Protect Health Information for purposes of treatment, payment and our health care operations. We may not use or disclose Protect Health Information for any reason other than treatment, payment and health care operations accept when (1) you give us your authorization form or (2) there is an exception described below. Further, you may revoke your Authorization in writing at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To avert a serious threat to health or safety** - We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety or the public or another person.
- **Public health activities -** We may disclose Protected Health Information for the following public health activities and purposes: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health

authorities or other government authorities authorized by law to receive such reports; (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

- **Victims of Abuse, neglect or Domestic Violence** – We may disclose Protected Health Information without Your Consent or Your Authorization to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. This may include a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.
- **Health Oversight Activities** - We may disclose Protect Health Information to a health oversight agency that is responsible for a health care system or that ensures compliance with the rules of government health programs such as Medicare or Medicaid.
- **Judicial and Administrative Proceedings** - We may disclose Protected Health Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. [164.512(e)] However, unless authorized by court order, we may not use or disclose Protected Health information identifying you as a recipient of substance abuse treatment or concerning such treatment if the purpose is to initiate or substantiate any criminal charges against you or to conduct any investigation of you.
- **Law and Enforcement Officials** – We may disclose Protected Health Information to the police or other law enforcement officials as required by law or in compliance with a court order.
- **Decedents** – We may disclose Protected Health Information to a coroner or medical examiner as authorized by law.
- **Research** – We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.
- **Specialized Government Functions** – We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends** - We may disclose health information about you to your family members or friends if we obtain your authorization to do so. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into your session.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy** – You have the right to inspect and receive a copy of your health information, such a clinical and billing records, that we keep and use to make decisions about your care you must submit a written request to our receptionist in order to inspect and/or copy records or your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

- **Right to Amend** – You have the right to request that we amend Protect Health Information maintained in your record file or billing records. If you desire to amend your records, please obtain an amendment request form from the receptionist and submit the completed form to your therapist.

  We may deny your request for an amendment if your request is not in writing or does not include your reason to support that request. In addition, we may deny your request if you ask us to amend information that (1) we did not create, (2) is not part of the health information that we keep, (3) you would not be permitted to inspect and copy, or (4) is accurate and complete.

- **Right to an Accounting of Disclosures** – You have the right to request and "accounting of disclosures." This is a list of disclosures we made regarding clinical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. In addition, the list will not include any disclosures we have made based on your written authorization.

  To obtain this list, you must submit your request in writing to the billing department. It must state a time period, which may not be longer than six years and may not include dates before February 1st, 2015. If you request an accounting more than once during a twelve (12) month period, we may charge a fee.

- **Right to Request Restrictions** – You may request that we limit our uses and disclosures of your Protected Health Information for treatment, payment, and health care operations purposes. However, by law, we do not have to agree to your request. To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION USE OF CLINICAL INFORMATION FORM to the receptionist. We will send you a written response.
- **Right to Request Confidential Communications** – You have the right to request that we communicate with you about clinical matters in a certain way or a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communication, you need to complete and submit the REQUEST FOR RESTRICTION USE OF CLINICAL INFORMATION to the receptionist. We will not ask you the reason for your request. We will attempt to accommodate all the reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Receive a Copy of this Notice** – You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effect date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

Can I plan now for the mental health treatment I would want if I were in crisis?

If you have a disability and need this document in an alternative format, please call 503-945-9716 (voice) or 800-375-2863 (TTY).

A Guide to Oregon's

Declarations for Mental Health Treatment

Revised April 2015

ANSWERS TO QUESTIONS

Planning for Your Mental Health Treatment

Can I plan now for the mental health treatment I would want if I were in crisis?

Yes. You can plan now for a time when you may be unable to make your own mental health treatment decisions.

How can I plan ahead?

Oregon has a form that you can fill out and sign now to protect yourself when you may be in crisis and are unable to make your own treatment decisions. This form is called a **Declaration for Mental Health Treatment.**

Who decides if I am unable to make my own treatment decisions?

Only a court or two physicians can decide if you are unable to understand and make decisions about your mental health treatment.

*A **Declaration** form is used only when you are unable to understand and make decisions about your mental health treatment*.

What kind of advance planning does Oregon's Declaration for Mental Health Treatment allow me to make?

You can make choices about your future mental health care. You can describe the kind of care that you want to receive. You can also describe the kind of care you do not want to receive.

You can also provide additional information about your mental health treatment needs.

It is wise to prepare this part of the Declaration carefully. You may want to discuss this section with your physician or mental health provider.

Can I ask someone to speak for me when I am in crisis and can't speak for myself?

Yes. You can choose an adult to represent you. This should be someone you trust who can make decisions about your mental health care when you cannot do so for yourself. Of course, the person you name must agree to do so.

On the **Declaration** form the person you choose is called a *Representative*.

Do I have to choose a lawyer?

No.

Can my representative make mental health treatment decisions that change my own wishes for treatment?

No. Your representative *must* follow your wishes. It is wise to talk to your representative about your wishes.

Even if you have not made your wishes known, your representative must make decisions for you that are as close as possible to the kind of decision you would make yourself if you were capable of doing so.

Your physician is not required to give you the medicine you have chosen in your **Declaration** form if your physician believes that it is not good for you. However, your physician must have your representative's permission to give you a medicine that is not listed in the **Declaration**.

This is why it is important for you to choose someone who knows you well and whom you trust.

How can I make sure that my instructions will be followed?

In order for your instructions to be followed, you or your representative must give copies of your completed **Declaration** form to your physician or mental health provider. Your representative should keep a copy, and it is wise to keep a copy for yourself.

Can my instructions ever be changed?

Whether or not you have signed a **Declaration** form, if you are on an emergency psychiatric hold, or if you have been committed by a court, your physician may still give you medicine that you didn't want. Your physician can only do this under very strict legal guidelines.

If I make out and sign a Declaration for Mental Health Treatment will it be good forever?

No. A signed **Declaration for Mental Health Treatment** only will be valid for 3 years and must be renewed. However, should you become incapable of making mental health treatment decisions during these 3 years, the **Declaration** will remain until the time—whenever that may be—that you regain capacity to make your own decisions.

Can I change my written instructions for mental health treatment or cancel my Declaration form?

Yes. As long as you are able to understand the information given to you about the choices that you may make for your mental health treatment, you may change your written mental health treatment instructions or cancel your **Declaration** form.

Of course, in order to make sure that your wishes are followed, you *must* give your physician or mental health provider a new **Declaration** form that includes the changes you wish.

However, if a court or two physicians decide that you are *unable to understand your mental health treatment options and you are not capable of making choices about your mental health treatment,*

you will not be permitted to change your written instructions or to cancel your **Declaration** until the time that you regain capacity to understand your treatment options.

But, this is why you have written out your future wishes on this **Declaration for Mental Health Treatment** form: *You want to protect yourself when you are in crisis and are unable to make your own treatment decisions*.

If I move out of the state of Oregon, will my Declaration form be valid?

It depends on where you go. Each state has its own rules.

Can anyone force me to make out a Declaration for Mental Health?

No. *No one*--no insurer, no physician, no mental health treatment provider, nor any other person--is permitted to attempt to force you to make out a **Declaration** form. It should be your *free choice* to make out and sign the **Declaration for Mental Health Treatment**.

Witnesses who sign your **Declaration** form should be people whom you know and trust. They can verify that you signed the form by your own free choice, *without being forced*.

INSTRUCTIONS

It is entirely your choice as to whether or not you want to have a Declaration for Mental Health Treatment (**Declaration**).

Before you fill out your **Declaration**, you should carefully read the

"NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT"

as well as the

"NOTICE TO PHYSICIAN OR PROVIDER"

which are found on pages 8 through 9 of the **Declaration** form. These notices give you some general information about the **Declaration**.

Once you make your **Declaration**, it stays in effect for three (3) years unless you revoke it. After three years, it is not valid. You need to sign a new **Declaration**. If you are incapable at the end of three years to sign a new **Declaration**, the **Declaration** stays in effect until you are capable again.

If you decide that you do not want to have a **Declaration** or you want to change it, you can. To revoke the **Declaration**, you tell your doctor, your mental health provider, and anyone else who has your **Declaration** that you do not want it to be in effect. To be safe, you should do this in writing or get all the copies of the **Declaration** and tear them up. Also, you cannot revoke your **Declaration** during a time when you have been found incapable.

If there is anything in this document that you do not understand after reading the notices and the following instructions, then you should ask an attorney to explain it to you.

How To Fill Out A Declaration For Mental Health Treatment Form

First Things First

First, you must be mentally competent to make a **Declaration**. Second, you need an official form to fill out. You cannot make a legal **Declaration** without one. The form attached to these instructions is official and will be valid if it is correctly filled out, signed, and witnessed.

To be valid and effective, the form must:

a. Contain your name.
b. Be signed and dated by you.
c. Be signed and dated by two witnesses who were present when you signed the **Declaration**. They must believe you are mentally competent at the time you sign the form.
d. Contain your instructions about mental health treatment.

Follow these steps to make a legally valid ***Declaration for Mental Health Treatment***.

Step 1 – Name

Print or type your name legibly on the first line of the form after the word "I".

Step 2 – Choice of Decision Maker

In the next section, you must choose who will make decisions for you if you become incapable of giving consent for mental health treatment. You can choose either the person who will be treating you or a "Representative." Place your initials on the line next to your one choice.

Although the form does not say so, some people cannot act as your "Representative." People who CANNOT be your "Representative" are:

- Your doctor, mental health service provider, or an employee of your doctor or provider, unless you are related to that person.
- An owner, operator, or employee of a health care facility where you live or are a patient, unless you are related to that person.

If you do not appoint a "Representative" or if the person you appoint does not accept appointment or is disqualified from serving, all of the other instructions in the **Declaration** are still valid.

Step 3 – Appointed Representative

If you choose a "Representative," then fill in each blank with the information requested about that person on page 3 of the form. If you choose to designate someone to be the alternate to your "Representative," then complete the information regarding the alternate "Representative" also on page 3 of the form.

Step 4 – Directions for Mental Health Treatment

The next part of the form, which is entitles "DIRECTIONS FOR MENTAL HEALTH TREATMENT" is where you put your instructions about the mental health treatment you want and don't want. Your directions may include your wishes regarding medications, admission and staying at a mental health treatment facility (for no longer than 17 days), convulsive treatment as well as outpatient services. This section is divided into 3 separate parts, which are addressed in the instructions section as Step 4A, Step 4B, and Step 4C.

Step 4A – Mental Health Treatments That You Consent To

On page 4 of the form, under the "DIRECTIONS FOR MENTAL HEALTH TREATMENT" is where you put instructions about what types of mental health treatment you want to approve. If you want specific instructions to be followed by a provider or your "Representative," those instructions must be put here.

- If you want to give consent for certain types of drugs, then you should specify which particular medications you approve.
- If you want to give consent to any drug the doctor may recommend, state "I give consent for any medication that my doctor recommends for me."
- If you want to limit your consent in any way, such as to maximum dosage, or you want certain information considered such as allergies you may have, you may add these instructions or information. You may specify your conditions or limitations. You may also state why a specific medication in a specified dosage may be used.
- If you have a "Representative," it will be assumed that your "Representative" must consent to the dosage and type of medication.
- If you agree to short-term inpatient treatment, you may so specify. You may also specify the particular facility and/or provider you consent to for this short-term inpatient treatment.
- You may agree to convulsive treatment, which includes "shock treatment" or "ECT (electroconvulsive treatment)." If you want to make a decision in advance about this sort of treatment, you may do so in this section or in Step 4B. You may include a limitation on the number or type of treatments you consent to or a direction to consult your "Representative" for these decisions.
- If you state that you consent to any sort of mental health treatment, you will not necessarily receive it. A doctor must first recommend the treatment for your condition. Your consent does not give a doctor the right to make improper recommendations.

Step 4B – Mental Health Treatments That You Do Not Consent To

The next set of spaces for your to fill in on the form, at the top of page 5, is where you put instructions about what types of mental health treatment you do not consent to. If you want specific instructions to be followed by a provider or your "Representative," then those instructions must be put here. You should be aware that you may be treated without consent if you are held pursuant to civil commitment law or are in an emergency situation where your life or health is endangered.

- If you do not want to give consent for certain types of drugs or dosage, state that "I do not consent to the administration of the following medications: _____" and write down the names or types of drugs you are refusing.
- If you want to refuse to consent to taking all drugs, write: "I refuse to consent to taking all medications."
- If you want to explain your refusal of consent, this can be specified. For example, you may corroborate your refusal by documenting the adverse effects, allergies, or misdiagnoses you have experienced from a particular medication and/or mental health treatment.
- If you do not agree to short-term inpatient treatment, you may so specify. You may also specify that you do not agree to a particular facility and/or to a particular provider for this short-term inpatient treatment.
- If you do not agree to convulsive treatment and want to make a decision in advance about this sort of treatment, which includes "shock treatment" or "ECT (electroconvulsive treatment)", you may so state.

Step 4C – Additional Information About Your Mental Health

At the top of page 6 of the **Declaration** is where you put your additional information about your mental health needs. You may include anything relevant to your wishes regarding your mental health treatment in this section. The form asks you to consider mental health history, physical health history, dietary requirements, religious concerns, people to notify, and other matters of importance. "Other matters of importance" could be anything related to the treatment that you feel may improve your mental health.

- For example, you can say that when you are really upset, what calms you down the most is to sit quietly in a dark room with the door left open. On the other hand, you can specify that the worst thing for you when you are really upset is to be placed in a locked room. The doctor does not have to follow these instructions, but if the doctor is aware of what works and what does not work, s/he may be willing to treat you according to your wishes.
- If you recognize through your experience that regular participation in a consumer run drop-in center provides you with the greatest sense of relief, then you can request that your therapy include participation in a consumer run drop-in center. Your choice does not guarantee that any such program will be available.
- If you would like to ensure that somebody is or is not told that you are in crisis/the hospital, then you may so specify.

Step 5 – Your Signature

Sign and date the form at the bottom of page 6 on the **Declaration**. Do this in front of 2 witnesses. Your signature must appear in this place for any part of the directive to be effective.

Step 6 – Affirmation of Witnesses

Have your 2 witnesses sign and date the form on page 7 in the section headed ***"Affirmation of Witnesses."***

Some people CANNOT act as witnesses. People who CANNOT act as your witnesses include:

- Your "Representative" or alternate "Representative." Anyone you appoint in Step 2 ("Choice of Decision Maker") cannot be a witness.
- A physician or mental health service provider who is treating you, or a relative of a person who is treating you. Your case manager, any doctor who is treating you while you are in the hospital, your counselor or private psychiatrist cannot serve as witnesses.
- The owner or operator of the facility where you live, or a relative of one of these people. For example, if you live in a group home, the owner or staff of the group home cannot serve as witnesses. The same is true of staff at nursing homes, foster homes, board and care homes, etc.
- A person related to you by blood, marriage, or adoption.

When the witnesses sign the form they acknowledge that:

1. You signed the **Declaration**;
2. *They believe you were mentally competent at the time you signed the form*; and
3. *They believe that you were not under duress, fraud, or undue influence at the time you signed the form.*

Step 7 – Other's Signatures

If you have a "Representative," then make sure that your "Representative" has signed and dated the acceptance of appointment on page 7. Likewise, if you have an alternate "Representative," make sure that your alternate "Representative" has signed and dated the acceptance of appointment on page 7.

Step 8 – Hand Out Copies

Make sure that you give copies of the completed form to any doctor, mental health provider, or facility from which you expect to need treatment. If you have appointed a representative, make sure this person also has a copy. Your instructions cannot be followed if they are not known to exist.

Declaration for Mental Health Treatment

Attention: This is a legal document which contains important information regarding the affected person's preferences or instructions for mental health treatment.

Declaration for Mental Health Treatment

I, _____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment. I want this declaration to be followed if a court or two physicians determine that I am unable to make decisions for myself because of my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means treatment of mental illness with psychoactive medication, admission to and retention in a health care facility for a period up to 17 days, convulsive treatment, and outpatient services that are specified in this declaration.

Choice of Decision Maker

If I become incapable of giving or withholding informed consent for mental health treatment, I want these decisions to be made by: (INITIAL ONLY ONE)

_____ My appointed representative consistent with my desires, or, if my desires are unknown by my representative, in what my representative believes to be my best interests.

_____ By the mental health treatment provider who requires my consent in order to treat me, but only as specifically authorized in this declaration.

Appointed Representative

If I have chosen to appoint a representative to make mental health treatment decisions for me when I am incapable, I am naming that person here. I may also name an alternate representative to serve. Each person I appoint must accept my appointment in order to serve. I understand that I am not required to appoint a representative in order to complete this declaration.

I hereby appoint: NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____

to act as my representative to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

(OPTIONAL)

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my representative, I authorize the following person to act as my representative:

NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____

My representative is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my representative. If my desires are not expressed and are not otherwise known by my representative, my representative is to act in what he or she believes to be my best interests. My representative is also authorized to receive information regarding proposed mental health treatment and to receive, review, and consent to disclosure of medical records relating to that treatment.

Directions for Mental Health Treatment

This declaration permits me to state my wishes regarding my mental health treatments including psychoactive medications, admission to and retention in a health care facility for mental health treatment for a period not to exceed 17 days, convulsive treatment, and outpatient services

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes are: **I CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENTS**: (May include types and dosage of medications, short-term inpatient treatment, a preferred provider or facility, transport to a provider or facility, convulsive treatment, or alternative outpatient treatments.)

I DO NOT CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENT: (Consider including your reasons, such as past adverse reactions, allergies, or misdiagnosis. Be aware that a person may be treated without consent if that person is held pursuant to civil commitment law.):

ADDITIONAL INFORMATION ABOUT MY MENTAL HEALTH TREATMENT NEEDS: (Consider including mental or physical health history, dietary requirements, religious concerns, people to notify and other matters of importance.)

YOU MUST SIGN AND DATE HERE FOR THIS DECLARATION TO BE EFFECTIVE:

Signature and Date: _____

Affirmation of Witnesses

I affirm that the person signing this declaration:

a. Is personally known to me;
b. Signed or acknowledged his or her signature on this declaration in my presence;
c. Appears to be of sound mind and not under duress, fraud, or undue influence;
d. Is not related to me by blood, marriage, or adoption;
e. Is not a patient or resident in a facility that I or my relative owns or operates;
f. Is not my patient and does not receive mental health services from me or my relative; and
g. Has not appointed me as a representative in this document.

Witnessed by:

Signature of Witness	Printed Name	Date
Signature of Witness	Printed Name	Date

Acceptance of Appointment as Representative

I accept this appointment and agree to serve as representative to make mental health treatment decisions. I understand that I must act consistently with the desires of the person I represent, as expressed in this declaration or, if not expressed, as otherwise known by me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document gives me authority to make decisions about mental health treatment only while that person has been determined to be incapable of making those decisions by a court or two physicians. I understand that the person who appointed me may revoke this declaration in whole or in part by communicating the revocation to the attending physician or other provider when the person is not incapable.

Signature of Representative	Printed Name	Date
Signature of Alternate Representative	Printed Name	Date

Notice to Person Making A Declaration for Mental Health Treatment

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about certain types of mental health treatment: psychoactive medication, short-term (not to exceed 17 days) admission to a treatment facility, convulsive treatment, and outpatient services. Outpatient services are mental health services provided by appointment by licensed professionals and programs. The instructions that you include in this declaration will be followed only if a court and two physicians believe that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for treatments. Your instructions may be overridden if you are being held pursuant to civil commitment law.

You may also appoint a person as your representative to make treatment decisions for you if you become incapable. The person you appoint has a duty to act consistently with your desires as stated in this document or, if not stated, as otherwise known by the representative. If your representative does not know your desires, he or she must make decisions in your best interests. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your representative at any time. A "representative" is also referred to as an "attorney-in-fact" in state law but this person does not need to be an attorney at law.

This document will continue in effect for a period or three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have not been determined incapable**. YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT OR TWO PHYSICIANS.** A revocation is effective when it is communicated to your attending physician or other provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge you signature.

Notice to Physician or Provider

Under Oregon law, a person may use this declaration to provide consent for mental health treatment or to appoint a representative to make mental health treatment decisions when the person is incapable of making those decisions. A person is "incapable" when, in the opinion of a court or two physicians, the person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions. This document becomes operative when it is delivered to the person's physician or other provider and remains valid until revoked or expired. Upon being presented with this declaration, a physician or provider must make it a part of the person's medical record. When acting under authority of the declaration, a physician or provider must comply with it to the fullest extent possible. If the physician or provider is unwilling to comply with the declaration, the physician or provider may withdraw from providing treatment consistent with professional judgement and must promptly notify the person and the person's representative and document the notification in the person's medical record. A physician or provider who administers or does not administer mental health treatment according to and in good faith reliance upon the validity of this declaration is not subject to criminal prosecution, civil liability, or professional disciplinary action resulting from a subsequent finding of the declaration's invalidity.

This Guide to Oregon's Declaration for Mental Health Treatment and Form was developed pursuant to Oregon Revised Statutes (ORS) 127.700 through 127.736.

Oregon Voter Registration Card

Clear Form | Print Form | Save As

SEL 500 rev. 01/17

you may use this form to:

→ **register to vote**

→ **update your information**

If you are 17, you will not receive a ballot until an election occurs on or after your 18th birthday.

The deadline to register to vote is the 21st day before an election

Only registered voters are eligible to sign petitions

1. **Print with a black or blue pen to complete the form.**
2. **Sign the form.**
3. **Mail or drop off the form at your County Elections Office.**

   Your County Elections Office will mail you a Voter Notification Card to confirm your registration.

oregonvotes.gov

1 866 673 VOTE / 1 866 673 8683
se habla español

TTY 1 800 735 2900
for the hearing impaired

information disclosure

Information submitted on an Oregon Voter Registration Card is public record. However, information submitted in the Oregon Driver's License section is, by law, held confidential.

assistance

If you need assistance registering to vote or voting please contact your County Elections Official. See reverse for contact info.

You must provide your valid Oregon Driver's License, Permit or ID number.
A suspended Driver's License is valid, a revoked Driver's License is not valid.

-or-

If you do not have valid Oregon ID, provide the last four digits of your Social Security number.

-or-

If you do not have a Social Security number or valid Oregon identification, provide a copy of one of the following that shows your name and current address:

acceptable identification:

- → valid photo identification
- → a paycheck stub
- → a utility bill
- → a bank statement
- → a government document
- → proof of eligibility under the Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) or the Voting Accessibility for the Elderly and Handicapped Act (VAEH)

qualifications

Are you a citizen of the United States of America? ☐ yes ☐ no

Are you at least 17 years of age? ☐ yes ☐ no

If you mark no in response to either of these questions, do not complete this form.

personal information **required information*

last name* | first* | middle

Oregon residence address (include apt. or space number)* | city* | zip code*

date of birth (month/day/year)* | county of residence

phone | email

mailing address (required if different than residence)

Oregon Driver's License/ID number

Provide a valid **Oregon Driver's License, Permit or ID**:

☐☐☐☐☐☐☐☐☐

☐ *I do not have a valid **Oregon Driver's License/Permit/ID**. The last 4 digits of my Social Security Number (SSN) are:*

x x x - x x - ☐☐☐☐

☐ *I do not have a valid Oregon Driver's License/Permit/ID or a SSN. I have attached a copy of **acceptable identification**.*

political party

☐ Not a member of a party

☐ Constitution
☐ Democratic
☐ Independent
☐ Libertarian
☐ Pacific Green
☐ Progressive
☐ Republican
☐ Working Families
☐ Other _____

signature *I swear or affirm that I am qualified to be an elector and I have told the truth on this registration.*

sign here _____ date today _____

If you sign this card and know it to be false, you can be fined up to $125,000 and/or imprisoned for up to 5 years.

registration updates *Complete this section if you are updating your information.*

previous registration name | previous county and state

home address on previous registration | date of birth (month/day/year)

Christian Community Placement Center

MHC Intake Packet – Adult

Secretary of State
Dennis Richardson
Salem OR 97310-0722

first class
postage
required

OFFICIAL ELECTION MAIL

Oregon Voter Registration Card

please write your County Elections Office address below:

fold card here

Baker County
1995 3rd St, Ste 150
Baker City OR 97814-3398
541 523 8207

Benton County
120 NW 4th St, Rm 13
Corvallis OR 97330
541 766 6756

Clackamas County
1710 Red Soils Ct, Ste 100
Oregon City OR 97045
503 655 8510

Clatsop County
820 Exchange St, Ste 220
Astoria OR 97103
503 325 8511

Columbia County
Courthouse
230 Strand St
St. Helens OR 97051-2089
503 397 7214

Coos County
Courthouse
250 N Baxter
Coquille OR 97423-1899
541 396 7607

Crook County
300 NE 3rd, Rm 23
Prineville OR 97754-1919
541 447 6553

Curry County
94235 Moore St, Ste 212
Gold Beach OR 97444
541 247 3297
1 877 739 4218

Deschutes County
1300 NW Wall St, Ste 202
PO Box 6005
Bend OR 97708-6005
541 388 6546

Douglas County
PO Box 10
Roseburg OR 97470-0004
541 440 4252

Gilliam County
PO Box 427
Condon OR 97823-0427
541 384 2311

Grant County
201 S Humbolt, Ste 290
Canyon City OR 97820-0039
541 575 1675

Harney County
Courthouse
450 N Buena Vista #14
Burns OR 97720
541 573 6641

Hood River County
601 State St
Hood River OR 97031-1871
541 386 1442

Jackson County
1101 W Main St, Ste 201
Medford OR 97501-2369
541 774 6148

Jefferson County
66 SE "D" St, Ste C
Madras OR 97741
541 475 4451

Josephine County
PO Box 69
Grants Pass OR 97528-0203
541 474 5243

Klamath County
305 Main St
Klamath Falls OR 97601
541 883 5134
1 800 377 6094

Lake County
513 Center St
Lakeview OR 97630-1539
541 947 6006

Lane County
275 W 10th Ave
Eugene OR 97401-3008
541 682 4234

Lincoln County
225 W Olive St, Rm 201
Newport OR 97365
541 265 4131

Linn County
300 4th Ave SW
Albany OR 97321
541 967 3831

Malheur County
Courthouse
251 "B" St W, Ste 4
Vale OR 97918
541 473 5151

Marion County
555 Court St NE, Ste 2130
PO Box 14500
Salem OR 97309-5036
503 588 5041
800 655 5388

Morrow County
PO Box 338
Heppner OR 97836-0338
541 676 5604

Multnomah County
1040 SE Morrison St
Portland OR 97214-2495
503 988 3720

Polk County
850 Main St
Dallas OR 97338-3179
503 623 9217

Sherman County
PO Box 365
Moro OR 97039-0365
541 565 3606

Tillamook County
201 Laurel Ave
Tillamook OR 97141
503 842 3402

Umatilla County
216 SE 4th St, Ste 18
Pendleton OR 97801
541 278 6254

Union County
1001 4th St, Ste D
LaGrande OR 97850
541 963 1006

Wallowa County
101 S River St, Rm 100
Enterprise OR 97828
541 426 4543 ext 15

Wasco County
Courthouse
511 Washington St, Rm 201
The Dalles OR 97058
541 506 2530

Washington County
3700 SW Murray Blvd, Ste 101
Beaverton OR 97005
503 846 5800

Wheeler County
PO Box 327
Fossil OR 97830-0327
541 763 2400

Yamhill County
Elections
414 NE Evans St
McMinnville OR 97128-4607
503 434 7518

Christian Community Placement Center

MHC Intake Packet – Adult

By signing below, I am

- Agreeing that I have read and reviewed **CCPC's standards** for
  - **Appointments**
  - **Cancellations**
  - **Consent to treatment**
  - **Fees**
  - **Payments of fees**
  - **PCP communication**
  - **Reminder phone calls**
- Agreeing that I read and received the list of **individual rights**.
- Agreeing that I read and received **CCPC's individual client's guidelines**.
- Agreeing that I read and received **CCPC's grievance procedure**.
- Agreeing that I read and received **The Notice of Privacy Practices.**
- Agreeing that I read and received my therapist's **Professional Disclosure Form.**
- I understand that counseling is a structured process which depends upon building relationship and consistent participation over time, and as the parent/guardian, that part of my role in my child's treatment is to ensure that my child attends all scheduled appointments.

I was given the opportunity to register to vote in the State of Oregon (check one):

- ☐ Accepted
- ☐ Declined, with the understanding that I can obtain a voter registration card from the receptionist at any time in the future.

I was given the opportunity to complete a Declaration of Mental Health

- ☐ Accepted
- ☐ Declined, with the understanding that I can fill out a Declaration of Mental Health at any time in the future. A packet can be obtained from the receptionist or my Therapist.

Client Name Date