SYMMETRY CARE

Name: _____ Date: _____

1. What type of services are you seeking today? (Circle all that apply)

   A. Mental Health
   B. Alcohol & Drug
   C. DUII
   D. Anger Management
   E. Domestic Violence

2. Are you mandated for services? **YES** or **NO**

   If yes, who is mandating you for services? _____

3. If you are being referred for services who referred you? _____

4. Where is your primary care provider located? _____
   Who is your Primary Care Provider: _____

5. Are you on any medications? If yes, please list what medications you are taking,

_____ _____ _____

_____ _____ _____

_____ _____ _____

*** What Pharmacy do you use? _____

5. Do you have insurance? **YES** or **NO** if yes, what is your insurance? _____

***If no, please let the receptionist know so that you may speak to someone to see if you qualify for our sliding scale.***

## Enrollment

**Date:** _____ **County of Residence:** _____

**Legal Name:** (First, Last) _____**Last Name at Birth**: _____

**Date of Birth:** _____ **Gender Assigned:** M: _____F: _____Other_____

**Gender Identity (circle): Female, Male, Non-Binary, Transgender, Two Spirit, Questioning, Not listed, Uknown, Don't Know, Don't Understand the Question, Decline**

**Legal Guardian:** _____

**Address:** _____**City:** _____**State:** _____**Zip:**_____

**Physical:** *(if different from above address)* _____

**Home Phone:** _____**Cell Phone:** _____**Message Phone:** _____

**Would you like text or email reminders for your appointments:** Yes _____No _____

If yes, please choose: Text _____Email: _____Text & Email: _____

**Email:** _____***Reminders are automatically sent 24 hours prior to appointment time**

*** I acknowledge that email reminders may not be secure _____(initial here)

**Emergency Contact:** _____**Phone:** _____

**Marital Status:** Never Married _____ Married _____Separate _____Divorced _____Widowed _____

**Living Arrangement:**

____Private Residence (at home)

____Private Residence (with relative, non-related, or other)

____Residential Facility

____Residential Sub Acute Care Facility

____Alcohol & Drug Free Housing

____Homeless

____Foster Home

____Jail

____Prison

____Unknown

**Is this a recent living change?** Yes _____ No _____ *If yes, date of change:* _____

**Are you?** Disabled: ____Not in labor force: ____Retired: ____Home Maker: ____ Student:____

Hospital Patient: ____Resident of another institution: ____Sheltered/ Non-competitive employment: ____

**Are you currently Employed?** Yes ____ No ____*If yes, are you part time or full time:* _____

**Employer:** _____ **Employer Phone:** _____

**Source of Income:** *(circle)* Public Assistance/Retirement/Wages/Salary/SSDI/None/Other/Unknown

**What is your monthly household income? _____**(*this includes SSI, Public Assistance, etc.)*

**Household Dependents:** Number of adults _____ Number of children under the age of 18 _____

**What is your race?**

___Alaskan Native

___American Indian

___Black or African American

___White

___Asian

___Native Hawaiian/ Other Pacific Islander

___Another Single Race

___Two or More Unspecified Races

**What is your Ethnicity?**

___Puerto Rican

___Mexican

___Cuban

___Other

___Hispanic

___Not of Hispanic Origin

___Unknown

**Do you have tribal affiliation?** Yes ___ No ___ (*Please Circle all that apply)* Burns Paiute Tribe, Confederate Tribes of Coos, Lower Umpqua & Siuslaw, Confederate Tribes of Grand Ronde, Confederate Tribes of Siletz, Confederate Tribes of the Umatilla, Confederate Tribes of Warm Springs, Coquille Indian Tribe, Cow Creek Band of Umpqua Indians, Klamath Tribes or Other

**Are you a Veteran?** Yes _____No _____ If yes, what branch? _____

**Are you receiving services at the local VA?** Yes _____No _____

**Who referred you to Symmetry Care Inc? _____**

**Highest Grade of school Completed: _____**

**Tobacco Use?** Yes _____No _____

**Do you currently have insurance?** Yes _____No _____**County responsible for insurance: _____**

If yes, please provide your insurance card to the receptionist

**Do you have secondary insurance?** Yes _____No_____

*** To the best of my knowledge I verify that this information is true and accurate. ***

**Signature: _____Date: _____**

**Individual Rights in Accordance with OAR 309-019-0115**

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

(a) Choose from services and supports that are consistent with the assessment and 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;

Additionally:

- Community mental health and development disability services shall not be denied to any person on the basis of race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age (except when program eligibility is restricted to children, adults, or older adults,) familial status, marital status, source of income, and disability.
- Any person eligible for mental health and developmental disability services provided by one agency shall also be eligible for other mental health and developmental disabilities services provided by any other agency unless admission to the service is subject to diagnostic or disability category or age restrictions based on pre-determined criteria
- No person shall, on the basis of handicap, be excluded from the participation in, be denied benefits of, or otherwise be subjected to discrimination under any program or activity.
- No person shall be denied services or be discriminated against on the basis of age, diagnostic or disability category unless predetermined clinical or program criteria for service restrict the service to specific age, diagnostic groups or disability categories.
- You have a right to have a treatment environment provided to you that affords reasonable protection from harm, and affords reasonable privacy.
- You have a right to have services provided to you demonstrating awareness of sensitivity to gender appropriateness, gender differences, and cultural differences.
- You have a right to choose or refuse service unless otherwise ordered by a court. If you do refuse services, you have the right to not suffer any punitive consequences. If adverse consequences are expected to result from your refusal, you have the right to have those consequences explained to you or your legal guardian.

(b) Be treated with dignity and respect;

(c) 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 receive a copy of the written service plan;

Additionally:

- You have a right to access Peer Delivered Services

(d) Have all services explained, including expected outcomes and possible risks;

(e) 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;

Additionally:

- You have a right to expect your records are maintained in a confidential manner.

(f) 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;

**PLEASE REVIEW AND SIGN THE NEXT PAGE**

(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 services provided in residential programs or in day or partial hospitalization programs

(g) Inspect their service record in accordance with ORS 179.505;
(h) Refuse participation in experimentation;
(i) Receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence;
(j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
(k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
(l) Have religious freedom;
(m) Be free from seclusion and restraint;
(n) Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;
(o) 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;
Additionally:
- You have the right to have all information regarding your fees presented to you or your guardian in terms you understand. You or your legal guardian have the right to know the amount and schedule of payment of any fees to be charged to you. You will not be denied mental health or developmental disability services based on ability to pay; however, you may be denied future services if you display unwillingness to pay.

(p) Have Family and guardian involvement in service planning and delivery;
(q) Have an opportunity to make a declaration for mental health treatment, when legally an adult;
(r) File grievances, including appealing decisions resulting from the grievance;
Additionally:
- You have a right to have access to, or a photocopy of, the policy and procedures explaining the complaint and grievance process and you have a right to file a grievance or a complaint, free from retaliation. If you choose, you have a right to receive assistance in filling out that grievance or complaint form.

(s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
(t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
(u) Exercise all rights described in this rule without any form of reprisal or punishment.

(2) The provider shall give to the individual and, if appropriate, the guardian a document that describes the applicable individual's rights as follows:
(a) Information given to the individual shall be in written form or, upon requests, in an alternative format or language appropriate to the individual's need;
(b) The rights and how to exercise them shall be explained to the individual, and if applicable the guardian; and
(c) Individual rights shall be posted in writing in a common area.

Signature: _____ Date: _____

Printed Name: _____ Relationship to the Client: _____

# Client Grievance and Complaints Process

Symmetry Care, Inc. wishes to provide high quality services; therefore, suggestions for improvements of, or complaints about services are welcome. Symmetry Care, Inc. will promptly consider and respond to a client grievance relating to treatment. We prefer to correct the causes of the grievance informally and encourage both client and Symmetry Care, Inc. staff to resolve problems as they arise.

1. Symmetry Care (SC) intake staff will review a written copy of the complaint policy and process with you at the time of intake.
2. Acting receptionist will be responsible to have ample complaint forms available to you at all times.
3. Symmetry Care staff can be made available if you request help to:
    a. find the form, if necessary
    b. Fill out the form, if necessary
    c. seal the complaint in an envelope
    d. and inform the receptionist that a complaint form has been filed
4. Acting receptionist will be responsible to deliver the filed complaint form to the SC Program Manager or designee daily within 24 hours.
5. The Program Manager or designee will respond to the complaint form within:
    a. 30 working business days, or
    b. if the matter of the grievance is likely to cause harm to the client the grievance will be responded to within 48 working business hours.
6. You have the right to contact any of the following entities for grievances or complaints:
    a. The Division – 503-945-5763, TTY 800-375-2863, or email AMH.web@state.or.us
    b. Disability Rights Oregon – 503-243-2081
    c. Any applicable coordinated care organization (GOBHI) - 800-493-0040
    d. The Governor's Advocacy Office – 800-442-5238
7. If you are not satisfied with the decision, you may file an appeal in writing within ten working days of the date of SC's response to the grievance or notification of denial for services. The appeal shall be submitted to the Division, as indicated above.
    a. If you wish, SC staff will be made available to assist you with this process.
    b. The Division shall provide you a written response within ten working days of the receipt of your appeal; and
    c. If you are not satisfied with the appeal decision, you may file a second appeal in writing within ten working days of the date of the written response to the Division Director.

348 West Adams St. ● Burns, Oregon ● 97720 ● Phone 541-573-8376 ● Fax 541-573-8378

# Grievance and Complaint Form

**Name: _____Date: _____**

**Describe the nature of your grievance/complaint. Be sure to name all parties involves, the date that the event took place and all necessary information in order for a complete review of your grievance/complaint. If necessary, you may use the back of this form for more space to write.**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Client Signature:_____Date:_____**

**After Careful review Symmetry Care believes the following action is necessary to resolve the issue.**

_____
_____
_____
_____
_____
_____

**Symmetry Care Reviewers Signature: _____Date: _____**

**Referred for appeal? Yes_____No _____ Date: _____**

# Informed Consent for Services

You are in charge of your healthcare and all the decisions related to your care and services. You have a right to participate and lead in decisions regarding your health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

You have the right to be informed and have an understanding about your diagnosis, the proposed and planned treatment, including the intended outcome, nature and all available procedures involved in the proposed and planned treatment. You have a right to understand the risks, including any side effects of the proposed treatment, particularly alternatives offering less risk or other adverse effects. Please ask for any information you need at any point in your treatment to make clear and informed decisions.

Know that any consent given may be withheld or withdrawn in writing or orally at any time, when this occurs, we will document your choice in the medical record, as well as the potential consequences of revoking the informed consent to treatment.

It is important that you feel free to ask questions and gain an understanding of all aspects of your treatment. We are your care team and you are the leader of that team. We are glad you are here.

**Acknowledgment of Integrated Health Records: _____(INITIAL)** *I understand Symmetry Care has an integrated health record which allows mental health staff access to information related to substance use or treatment or any other services I receive from Symmetry Care; I am therefore authorizing Symmetry Care staff members who need access to my protected health information to access the minimum necessary information in my record for such purposes. This is with the assurance that my substance abuse treatment information will not be reviewed in detail and the fact that I am receiving substance abuse treatment will not be disclosed to other programs outside of Symmetry Care without my explicit written authorization unless required by law.*

**Telehealth Consent:** *I understand that telehealth services may be part of my care at Symmetry Care if my providers determine that such services are appropriate for my treatment. Telehealth services are health care services delivered by a provider at a different location from the client via two-way audio and video communications and/or by the electronic transmission of client information. Symmetry Care will identify the telehealth provider and the providers credentials whenever I receive such services. Symmetry Care has established security measures in relation to its use of telehealth technologies, including data encryption, secure networks, and password protected computers and applications. I understand that despite those measures, there are risks to privacy whenever personal information is transmitted and/or stored electronically. I also understand that information may be lost due to technical failures. Knowing these risks, I voluntarily consent to receive telehealth services to the extent they are determined to be appropriate by my provider.*

**Consent for Treatment Services:** *I understand and agree to the above information and terms of mental health and/or prevention and recovery services and consent to receiving services at Symmetry Care, INC.*

_____ _____

Signature Date

# Symmetry Care, Inc. Financial Agreement/ Insurance Agreement/ Confidentiality Agreement/ Attestation

Name: _____Date of Birth: _____

**Payment through Insurance**

Symmetry Care, Inc. has my permission to bill my insurance company(s) and to provide necessary information for the purposes of obtaining authorization for services, benefit information, and payment. I agree that payments or copays for services are due at the time of the service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay. I understand that no show or late cancelled sessions (less than 24-hour notice) will be charged to me at full fee and cannot be charged to my insurance company. I agree that an insufficient funds fee of $35.00 will be assessed for any returned check. **INITIAL** _____

By signing this page, I am authorizing Symmetry Care Inc. to release any information to my insurance company(s), which may be deemed necessary in order to process an insurance claim. I further authorize that my insurance benefits be paid directly to Symmetry Care, Inc. I agree to notify Symmetry Care, Inc. immediately whenever there are changes in my health condition or health plan coverage in the future.

***You may be eligible for sliding fee scale adjustment or payment plan for out-of-pocket charges that you may incur. Would you like to be contacted bout eligibility and/or additional information?***
***Yes_____No_____***

I agree that payments for services are due at the time of service and the responsibility for payment is mine. **INITIAL** _____

**Confidentiality Statement**

The staff at Symmetry Care, Inc. will keep all information about your case confidential, including that you are receiving services. There are certain times that our information may be shared without your consent. These are as follows: *If you should require emergency medical attention, if you report to us your intent to harm yourself or someone else, or if your records are subpoenaed by the court.* **INITIAL**_____

**Attestation**

By signing below, I understand my responsibilities and agree to the terms mentioned in the forms I have received and been offered. I understand these documents are available to me upon request at nay time. I agree to receive services from Symmetry Care, Inc. I acknowledge review of the following documents:

- Statement of Individual Rights
- Grievance Procedure and Sample Grievance/Complaint Form
- Voter Registration Information
- Notice of Privacy Policies

**Print Full Name:** _____

**Signature:** _____**Date:** _____