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QUEST CENTER FOR INTEGRATIVE HEALTH

Agency Registration Form

Today's Date: _____

Basic Info: ***While Quest recognizes a spectrum of gender/sex, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex on record with your insurance company must be used on documents pertaining to insurance and billing. However, please also let us know the gender, name, and pronouns that you would like us to use.***

_____

Legal Last Name Legal First Name MI Preferred Name Date of Birth

_____

Street Address Unit/Apt # City State Zip

County: _____ Housing Status: ☐ Permanent ☐ Temporary ☐ Houseless ☐ Other: _____

Gender Identity: ☐ Female ☐ Genderqueer/Non-Binary ☐ Trans ☐ Male ☐ Other: _____

Legal gender: ☐ Female ☐ Male ☐ Intersex Pronoun: ☐ She ☐ He ☐ They ☐ Other: _____

Contact Info:

Phone Number:	Cell:	Work:	Home:
Messages OK?	Yes / No	Yes / No	Yes / No

Email: _____ Appointment Reminders via: ☐ Phone ☐ E-mail ☐ None

Would you like to receive Quest's Electronic Newsletter? ☐ Yes ☐ No

Billing Information:

Insurance: ☐ Medicaid/OHP ☐ Medicare ☐ VA ☐ IHS ☐ Self-Pay ☐ Uninsured ☐ Private: _____

Primary Insurance Carrier	Insurance ID Number	Secondary Insurance Carrier, if applicable
Policy Holder's Name (If not you)	Policy Holder's Date of Birth	Relationship to You

Demographics: *Your optional responses help Quest develop culturally responsive and inclusive programs. As a Non-Profit, we collect this data in order to secure funding for marginalized populations, but understand that one's identity can't be reduced to a series of boxes.*

Do you think of yourself as: ☐ Lesbian/Gay ☐ Straight/Hetero ☐ Bi/Pan-sexual ☐ Queer ☐ Asexual ☐ Other

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Poly ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Please choose all options that best describe your racial or ethnic heritage:

☐ Black/African American ☐ White/European ☐ Middle Eastern/North African ☐ Asian: _____

☐ Native/Indian/Indigenous American: _____ ☐ Alaska Native/Eskimo ☐ Native Hawaiian/Pacific Islander

☐ Hispanic: _____ Latin American/Latinx/Caribbean ☐ Mexican/Chicanx/Xicanx ☐ Other: _____

Appx. Monthly income? $_____ How many people (including you) does your income support? _____

Military Status: ☐ N/A ☐ Active Duty ☐ Veteran ☐ Discharged ☐ Reserve

For Business Office Use Only:

Primary Location: ☐ Multnomah ☐ Clackamas

Program of Entry: ☐ Mental Health ☐ FSR ☐ Ryan White Mental Health ☐ HIV Peer Support ☐ Acupuncture ☐ Women of Wisdom (WOW) ☐ WISH Pain Management ☐ Naturopathy ☐ Osteopathy

Ind. Entering Data: _____ Date Entered: _____

Are you a: ☐ New Quest client? ☐ Returning Client? ***Name & Agency of Referral Source:**_____

How did you hear about us?: ☐ Quest Client/Provider ☐ Other Healthcare Provider ☐ Social Service Provider
☐ Insurance Company ☐ Ad/Brochure ☐ Quest Website ☐ Social Media/Facebook ☐ Other:_____

Emergency Contact Name | Relationship to you | Phone | Alt. Phone

Street Address | Unit/Apt # | City | State | Zip Code

Medical Provider Information:

Primary Care Physician | Medical Center | Location | Phone

Preferred Hospital | Location | Preferred Pharmacy

Sexual Health & Wellness:

Current HIV Status: ☐ HIV Positive ☐ Unknown Status ☐ HIV Negative

Permission to contact you regarding HIV Testing and Support Services? ☐ Yes ☐ No ***(If No, skip to next section)***

When calling, can we identify as HIV Services? ☐ Y ☐ N Does your Emergency Contact know your HIV Status? ☐ Y ☐ N

Would you like to receive monthly HIV Services mailing? ☐ Email ☐ US Post ☐ No, thanks!

Do you have CareAssist? ☐ Yes ☐ No Do you identify as a long-term survivor? ☐ Yes ☐ No ☐ Unsure

Please complete if you are a Youth under the age of 18 and/or have a legal guardian: ☐ N/A

Parent/Guardian Name | Primary Phone: | Alt. Phone:

May we leave a message identifying as Quest? ☐ Yes ☐ No

Street Address | Unit/Apt # | City | State | Zip Code

For Motor Vehicle Accidents Only: ☐ Does Not Apply

Date of Accident | Claim # | Name of Claim's Adjuster | Phone

Attorney's Name (If Applicable) | Attorney's Address | Phone

I certify that the above information is true and accurate:

Client/Patient Signature | Date | Parent/Guardian Signature | Date

OFFICE USE ONLY
Clinician's Initials: _____ Date: _____

Client Name: _____ **Date:** _____

1. What are your mental health goals?

_____
_____
_____
_____

2. Why are you seeking care now?

_____
_____
_____
_____

3. Are you having problems with any of the following *(Please check all that apply.)*

	Anger		Impulse control		Relationship problems
	Anxiety		Indecisiveness		Restlessness
	Appetite, excessive		Lack of motivation		Sleeplessness
	Appetite, low		Low energy		Stress
	Concentrating		Memory loss		Suicidal thoughts
	Crying frequently		Mood swings		Thought control
	Depressed Moods		Nervousness		Too much energy
	Domestic violence		Nightmares		Too much guilt
	Extreme tiredness		Oversleeping		Weight control
	Feeling worthless		Panic attacks		Worrying too much
	Hopelessness		Racing thoughts		Hearing Voices

Comments:

_____
_____
_____
_____

4. It is important for us to know about your past as well as present situation. Childhood experiences shape our mental and emotional health. Thinking of the following items as they relate to your childhood and early adult life, please check all that apply.

	Frequent moves (of residence)		Your mother was treated violently
	Serious physical illness in your family		Repeated emotional humiliation
	Death of a family member		Physical abuse
	Abuse by parents or others		Emotional neglect
	Sexual abuse		Problems in school
	Running away		Physical neglect
	A member of your household was chronically depressed, suicidal, or mentally ill		
	For part of your childhood you did not live with both of your biological parents		
	A member of your household abused drugs or alcohol		
	A member of your household was imprisoned		
	None.		

Quest Center for Integrative Health
2901 E. Burnside, Portland, OR 97214 | Phone: 503.238.5203 | Fax: 503.238.5202 | info@quest-center.org

5. Changes in your life often produce emotional stress. During the past year, have you experienced any of the following changes?

	Work problem or work changes		Family problems
	Personal health problems		Legal problems
	Change in living situation		Sexual problems
	Alcohol or drug problems		Eating disorder
	Financial problems		Gambling problems
	Death or illness of a family member (including chosen family)		Relationship problems
	Other significant life change.		

6. Mental health and physical health greatly influence each other. Please share updates to any of the following information that may have changed since your last interaction with a Quest Mental health clinician:
   a. Any updates to medications prescribed by a doctor or over the counter drugs? ☐ Yes ☐ No
   To the best of your knowledge, please list all of your medications and dosages:

   _____

   _____

   b. Any updates to diagnosed health/medical conditions? ☐ Yes ☐ No
   Please share the details:

   _____

   _____

Substance Use

Have you ever used:	*Yes*	*No*	*Last Used (Date)*	*Method*	*Frequency*
Alcohol					
Do you think you have a problem with alcohol?					
If no alcohol use, how long have you been sober?					
Marijuana/Hash					
Cocaine/Crack					
Crystal Meth/Amphetamine/Speed					
Heroin					
Codeine					
Barbiturates/Downers					
Tobacco					
Do you struggle with pain medications or anti-anxiety medications as prescribed?					
Do you struggle with or feel that you have a gambling problem?					

7. What brings positivity to your life?

   _____

   _____

8. Please describe your image of a "safe space."

   _____

   _____

9. Is there anything else you would like us to know?

   _____

   _____

Client Signature: _____ **Date:** _____

Client Information for the State of Oregon Tracking (MOTS)

Please fill out as much as you can, if you have any questions, please ask your therapist. Please fill out both sides.

First Name :_____ **Date of Birth:** _____/_____/_____

Last Name :_____ **Today's date:**_____/_____/_____

Last Name at Birth:_____ **Therapist's name**_____

Race *(All that apply)*----------

- ☐ Alaska Native
- ☐ American Indian
- ☐ Black or African American
- ☐ White (Caucasian)
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Single Race
- ☐ Two or More Unspecified Races

Ethnicity----------

- ☐ Not of Hispanic Origin
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Specific Hispanic
- ☐ Hispanic – Specific origin not specified
- ☐ Unknown

Gender----------

- ☐ Female
- ☐ Male
- ☐ Other

Marital Status----------

- ☐ Never Married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Veteran----------

- ☐ No
- ☐ Yes, Veteran and not specified Branch of Service
- ☐ No, but Current or Former Guard /Reserve Military
- ☐ Yes, Veteran and Current or Former Active Duty Military
- ☐ No, but Current or Former Guard /Reserve Military
- ☐ Yes, Veteran and Current or Former Active Duty Military

Competitive Employment----------

- ☐ Full Time
- ☐ Part Time
- ☐ Unemployed
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Disabled (unable to work for physical or psychological reasons)
- ☐ Hospital Patient or Resident of Other Institutions
- ☐ Other Reported Classification (e.g. volunteers)
- ☐ Sheltered/Non-Competitive Employment
- ☐ Not in Labor Force

Living Arrangement----------

- ☐ Other Private Residence
- ☐ Private Residence (at home)
- ☐ Private Residence (with non-relative)
- ☐ Private Residence (with relative)
- ☐ Transient/Homeless
- ☐ Residential Facility
- ☐ Residential Facility
- ☐ Residential Sub-Acute Care Facility
- ☐ Room and Board
- ☐ Supported Housing
- ☐ Supportive Housing (scattered site)
- ☐ Supportive Housing (congregate setting)
- ☐ Alcohol and Drug Free Housing
- ☐ Oxford Home
- ☐ Room and Board

County of Residence: _____

Zip Code of Residence:_____

Estimated Gross Household Monthly Income----------

- ☐ Monthly income_____
- ☐ No income
- ☐ I prefer not to answer

Source of Income/ Support----------

- ☐ Wages/Salary
- ☐ Public Assistance
- ☐ Retirement/Pension/SS

☐ Disability/SSDI ☐ Other ☐ None

Primary Health Insurance----------

☐ Private Insurance/Managed Care Organization ☐ Medicare ☐ Medicaid/OHP ☐ Other ☐ None

Expected/ Actual Source of Payment ***(All that apply)***----------

☐ Medicaid/OHP ☐ Private Health Insurance ☐ Medicare ☐ Other _____

Total Number of Dependents (including yourself) _____ **Number of Child Dependents** (Number of children ages 0-17 yr) _____

Referred From *(All that apply)* _____

Tribal Affiliation----------

☐ Not Applicable ☐ Tribe:_____

Interpreter----------

☐ None ☐ Hearing Impaired ☐ Foreign Language

Pregnant----------

☐ Yes ☐ No ☐ Not Applicable

Highest School Grade Completed (number) ____

Tobacco Use----------

☐ Yes ☐ No

Substance Use during last 90 days----------

☐ Yes ☐ No

Legal Status *(All that apply)*----------

☐ **None**
☐ DUII Diversion Client
☐ DUII Convicted Client
☐ 30 Day Civil Commitment
☐ 90 Day Civil Commitment
☐ 180 Day Civil Commitment; Incarcerated
☐ Parole
☐ Probation
☐ Psychiatric Security Review Board (PSRB)
☐ Juvenile Psychiatric Security Review Board (JPSRB)
☐ Guardianship (Court or Child Welfare)
☐ Aid and Assist (ORS 161.370)

For office use only----------

Diagnosis DSM 5/ ICD-10 Code(s). *(All that apply)*

Peer Delivered Services----------

- o Client was informed of Peer Delivered Services
- o Client Received Peer Delivered Services
- o Peer Delivered Services Planned as Part of Transition Plan/Discharge
- o None
- o Not Applicable

Infectious Disease Risk Assessment----------

- o Not completed
- o Low-to-No Risk
- o Moderate-to-High Risk/No referral
- o Moderate-to-High Risk/Referral was made

Treatment Plan Indicator- Indicate the areas of performance addressed in the client's treatment care plan.----------

☐ Education ☐ Employment ☐ Housing ☐ Other

Acknowledgement, Consent, Confidentiality, Office Policy and Rights and Responsibilities

Consent to treatment: I hereby voluntarily consent to the provision of medical, mental health, substance use disorder or HIV services at Quest Center for Integrative Health (hereafter referred to as Quest Center) as may be deemed medically advisable or necessary. I request that my health care provider(s) provide any care they think is necessary and consistent with my instructions except_____. I understand this care may include tests, examinations, medical and minor surgical treatment and related anesthesia. I acknowledge that the health care providers treating me may be independent contractors, supervised interns, or employees of Quest Center. If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by my health care provider(s) during each visit. I understand that if special procedures or operations are needed, my health care provider will discuss this with me and my additional consent will be required. I understand that I have the right to participate in the development and periodic review of my individualized treatment plan, and to be informed of my diagnosis (after the assessment has been completed) and the purpose of any prescribed medication and potential side effects of the medication. I understand that some Quest Center practitioners are involved in teaching and I consent to having student providers and other trainees and volunteers involved with my care. I understand that I may revoke my consent at any time, but action taken by Quest Center before that time will remain covered by this authorization.

Consent for movement classes, groups, workshops, and activities

I may choose to participate in classes or services during which I will receive information and instruction about movement and health. I recognize that movement classes, groups, workshops, or other movement activities (hereafter referred to collectively as Quest Movement Activities) require physical activity, which may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved.

I understand that it is my responsibility to consult with a clinician prior to and regarding my participation in any physical fitness program, including Quest Movement Activities. I represent and warrant that I will not participate in Quest Movement Activities if I have any medical condition that would prevent my safe participation in physical fitness activities.

In consideration of being permitted to participate in Quest Movement Activities, I agree to assume full responsibility for any risks, injuries or damages, known and unknown, which I might incur as a result of my participation.

I understand and voluntarily accept any and all risk and agree that Quest Center, its officers, directors, employees, trainees, volunteers, agents and independent contractors will not be liable for any injury, including, without limitation, personal, bodily, or mental injury, economic loss or any damage to me resulting from participating in Quest Movement Activities and using the facility in which they are held.

Further, I understand and acknowledge that Quest Center does not manufacture equipment for Quest Movement Activities at its facility, but rather, purchases the equipment. I understand and acknowledge that Quest Center is providing this service and may not be held liable for defective products.

Consent for treatment with manual medicine

I understand that several of the Quest Center clinicians provide various types of manual medicine or "hands on" treatment of the body, based on the concept that the structure of the human body influences its function. Receiving this type of treatment is entirely voluntary. Depending on the provider's preferences and skills, these may include a wide variety of techniques, from very gentle low-force approaches to more "direct" thrust types of techniques. The goal of treatment is to improve the body's structure, which enables the body to function at a high level of health. This usually reduces the amount of pain experienced by the patient. As in most forms of medical treatment, no specific results can be guaranteed.

I understand that patients rarely experience side effects, particularly with the low force forms of treatment that most Quest Center providers use. These are considered among the safest and most non-invasive forms of medical treatment available. However, for the purposes of disclosure, when looking at a compilation of all forms of manual medicine treatment, the following side effects have been reported:

In more common cases, patients may experience mild muscle soreness, tenderness, fatigue, or flu-like symptoms, similar to those experienced after excessive sports activities. This vital reaction to treatment usually resolves within a few days.

Rarely, patients may experience worse pain or other symptoms after treatment, numbness or weakness, fractures (broken bones), spread of pre-existing

conditions such as undetected cancer, breaking loose of blood clots, stroke, and tears in blood vessels.

I understand that, although the above listed complications are rare, some of these complications may be serious. Utilizing gentle techniques significantly reduces their already low rate of occurrence, but Quest Center cannot guarantee that they will never occur.

Medical records policy: I understand that my medical records are the property of Quest Center. Information may be shared among practitioners of Quest Center for purposes such as treatment or other health care operations, including but not limited to coordination of care in an integrated setting, quality assurance activities, utilization review activities, and peer review. If I am referred to practitioners outside of Quest Center, any necessary information may be shared with them as well, in order to facilitate and coordinate my health care; however, a release of information form will be required for this information sharing. In addition, Quest Center will provide necessary documentation to my insurance company for purposes of claims review and payment. All of this is done pursuant to my consent, as indicated by my signature at the bottom of this document.

Consent to release information: I consent to allow Quest Center to release my confidential health information for purposes of treatment, payment and health care operations. In particular, I consent to the release of my confidential health information for the following purposes: (1) for the diagnosis, treatment and/or evaluation of any health condition, including the sharing of information by and among Quest Center providers and outside health care providers; (2) as required by my insurance carrier for the purposes of reviewing and paying claims for services rendered by Quest Center providers; (3) for the performance of quality assurance, utilization review, and/or peer review activities; (4) for the determination of eligibility under my insurance health plan; (5) as required by any governmental agency or any entity responsible for processing or paying my claims for medical benefits, including Worker's Compensation claims; and (6) as otherwise authorized by law. I understand that I may revoke my consent at any time, but action taken by Quest Center before that time will remain covered by this consent. I understand that information from my medical record may be reviewed or released while I am receiving care or after discharge and this information will be held confidential except as allowed by law.

I understand that Quest Center for Integrative Health will use and disclose health information about me.

I understand that my health information may include information both created and received by Quest Center, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Quest Center may use and disclose my health information in order to:

- Make decisions about, and plan for, my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my clinician's efforts to provide me with, arrange and be reimbursed for, quality, cost-effective health care.

I understand that if applicable, my health information, both created and received by Quest Center, may be used within the context of mandatory and necessary reporting related, but not limited to, statistics, funding or grants, that may be required by local, state and/or federal agencies.

I also understand that I have the right to receive and review a written description of how Quest Center will handle health information about me. This written description is known as a *Notice of Privacy Practices* and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Quest Center, and my rights regarding my health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time, and that I am entitled to receive a copy of any revised *Notice of Privacy Practices.* I also understand that a copy of the most current version of Quest Center's *Notice of Privacy Practices* in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the *Notice of Privacy Practices,* and I understand that Quest Center is not required, by law, to agree to such requests.

Client Confidentiality Agreement: As a client of Quest Center, I may learn of confidential information relating to both potential and existing clients within an alcohol and drug recovery environment, as well as any other services that Quest Center provides inside and outside a clinical setting. I may be exposed to protected health information, including, but not limited to, general and specific client-related information, personal information, financial information that is related to employment or disability, or other information not generally disclosed by Quest Center to the public. This information may be in written or verbal form, electronically generated or created by any other means of transmission. Unauthorized access, discussion, review, disclosure, transmission, alteration, dissemination, or destruction of such information, except as required to fulfill the responsibility of Quest Center, is absolutely prohibited.

Purpose: To ensure that personal and protected health information is safeguarded so that individuals are not afraid to seek health care or other services that Quest Center may provide. To also ensure that personal health information is protected during its collection, use, disclosure, storage and destruction within Quest Center.

Definitions: Protected Health information is defined as all information recorded or exchanged that relates to an individual's health, or health care history, including genetic information, about the individual, or the individual's family.

Protected health Information is described as the following:

Patient Name	E-Mail Addresses	Vehicle or Other Device Serial Numbers
Patient Address	Social Security Number	Web URL's
City & County of Residence	Medical Record Number	Internet Protocol Addresses (IP)
Zip Code	Health Plan Beneficiary Number	Finger or Voice Prints
Names of Relatives & Employers	Account Numbers	Photographic Images
Birth Date	Telephone & Fax Numbers	

Protected Health Information also includes conduct or behavior that may be a result of illness or the effect of treatment.

Policies: In accordance with this policy, I agree to protect and not to disclose confidential information. I agree that I have the responsibility to respect the confidentiality of the clients of Quest Center

Office Policies:

General: I am free to receive healthcare from any practitioners of my choice, either within or outside of Quest Center. As a patient of Quest Center, I will have the opportunity and choice to see one of Quest Center's medical, mental health, substance use disorder, pain management, or HIV services providers, according to my identified health care needs. Practitioners at Quest Center are either independent contractors, supervised students/ interns/ or residents at, or employees of, Quest Center. Each practitioner is solely responsible for any health care decisions and recommendations he or she may make. While all practitioners will be practicing within the scope of their individual licenses, some of the treatments they discuss with me may be considered experimental, new, or "alternative". I am solely responsible for deciding which treatment I will choose, although my provider(s) will assist me in reaching an informed decision. No guarantee is made as to the results that may be obtained from their examination or treatment.

After hours care: I understand that Quest Center recommends that I maintain a relationship with a primary care physician who can provide emergency care, since at this time, Quest Center does not offer emergency services. If an emergency arises, I agree to contact my primary care provider, call 911 or go to the nearest emergency room. If I have an urgent after-hours mental health issue, I will call the mental health crisis line at 503-988-4888, or call Quest Center's after-hours mental health urgent care line at 503-484-4816. If an urgent after-hours medical issue arises, I may reach my Quest Center medical provider through the answering service at 503-402-2513.

Insurance billing and payment for services: If I choose to have Quest Center bill insurance for me, I understand Quest Center requires that my deductible be met and that my co- payment or my portion of the bill be paid at the time of each visit. In the event that my insurance carrier determines that the services provided to me are not a covered benefit under my health care plan, I am responsible for the total amount due, as well as any applicable co-payment or deductible. A $20 fee will be charged for any returned checks. I may choose to purchase any recommended nutritional supplements, health care products, books, etc. at this location or elsewhere. In most cases, non-prescription pharmacy items are not covered by insurance and I will need to provide payment for these items at the time I receive them. I am responsible for updating Quest Center on any changes in my insurance carrier or policy status, as well as any changes in my address, telephone number, name, email address, or other relevant information. My signature below authorizes payment of all insurance or health plan benefits to be made directly to Quest Center or its practitioners

Medicare: At this time, most Quest Center practitioners are not authorized participating providers in the Medicare program and, therefore are unable to bill for or accept direct payment from Medicare. If, while I am a patient at Quest Center, I become eligible for Medicare, I must immediately inform the receptionist of this.

Workers Compensation: At this time, Quest Center practitioners are not accepting any worker's compensation claims. I must notify my practitioner and Quest Center receptionist if my visit is due to an injury covered by Worker's Compensation.

Past due accounts: I will be charged any necessary collection cost, including attorney's fees or collection agency fees, both at trial and on appeal, and whether a lawsuit is filed.

Appointment Reminders Policy: Reminder calls are made to the best of our ability and *as a courtesy*. Clients are still expected to take responsibility for making, keeping, and managing all appointment times. Provider or program-specific orientation materials can provide more information on program-specific policies on responding to calls.

NOTICE TO CLIENTS/ PATIENTS: Please sign and return the final page of this packet to your clinician upon review of all policies. By signing, you agree that you have read fully and understand the terms and conditions outlined herein regarding the office policy and use and/or disclosure of health information. You indicate that you understand and accept the policies listed in this agreement. You have reviewed and understand the permitted disclosures and give your consent to use your health information as named in the Acknowledgement, Consent, Confidentiality, Office Policy, and Rights and Responsibilities. You have asked questions about anything not clear to you, and you are satisfied with the answers you have received. You also certify that the information given by you is correct and you have read and consent to the terms of this policy, including payment for these services. You are the patient or authorized as the patient's agent or representative to execute the above and accept the terms on behalf of the patient, and you assume individually all financial responsibility by signing below. You understand you may revoke this consent at any time.

NOTE: Attachments will include:

Quest Center Cancellation Policy

Quest Center Phone, Text and E-mail policy

Quest Center Medication Management Policy

Quest Center Grievance Policy

Oregon Health Plan Member Rights and Responsibilities

Behavioral Health Fee Schedule

Client & Patient Notice of Cancellation Policies

Definitions for Cancelled Appointments

- Late Cancellation (LC): Appointment that is cancelled less than 24 hours in advance. For Monday appointments, any notification after the close of business on Friday will be considered less than 24 hours.
- Same-Day-Status (SDS): Client may only schedule appointments on the day they call to schedule. All previously scheduled appointments will be cancelled.

Medical Services

1. PLEASE NOTE: The Medical Department needs at least 48 Hours Notice for Any Cancellation. It is very difficult to fill cancellation spots with notice of less than 48 hours.

2. In the event of the first No Show or Late Cancellation the patient will receive a warning letter reminding them of our policy.

3. For all subsequent No Show or Late Cancellations, Quest may assess a charge of $35.00, and send another letter reminding the patient of our policy.

4. If a patient has three No Shows or Late Cancellations within a six-month period of time, they may be placed on Same Day Status for a three-month period.

5. Once the patient has consecutively shown up for two Same Day appointments, Quest may consider reversing their Same Day Status.

6. For New Patients:

   a. If the initial appointment is a No Show or Late Cancellation, the new patient will receive a warning letter reminding them of our policy, as mentioned above.

   b. If a new patient has a second No Show or Late Cancellation for an initial appointment, that provider will not take this person on as a patient.

Acupuncture

1. In the event of the first No Show or Late Cancellation the patient will receive a warning letter reminding them of our policy.

2. For all subsequent No Show or Late Cancellations, Quest may assess a charge of $35.00, and send another letter reminding the patient of our policy.

4. If a patient has two No Shows or Late Cancellations within a six-month period of time, they may be placed on Same Day Status for a three-month period.

5. Once the patient has consecutively shown up for two Same Day appointments, Quest may consider reversing their Same Day Status.

6. For New Patients:

a. If the initial appointment is a No Show or Late Cancellation, the new patient will receive a warning letter reminding them of our policy, as mentioned above.

b. If a new patient has a second No Show or Late Cancellation for an initial appointment, that provider will not take this person on as a patient.

Mental Health Services

1. No-Shows and Cancellations will not be accommodated for initial phone screens, mental health assessments, or psychiatric medication evaluations.

a. Clients wishing to engage in services following a no-show or cancellation for initial phone screens or mental health assessments will need to begin the entrance process again through contacting the business office.

b. Clients who reschedule their mental health assessment or psychiatric medication evaluation more than 24 hours in advance may not be able to get another appointment the same week and may delay their treatment by up to a month.

2. After the first No-Show or Cancellation in 6 months, the client will be contacted by their provider and their provider will work to identify barriers to appointment attendance.

3. After the second No-Show or Cancellation in 6 months, the client may be sent a letter reminding them of the Quest policy for No-Shows and Cancellations.

4. After the third No-Show or Cancellation in 6 months, the client may be limited to Same Day appointments (client may call and schedule only for the day they are calling, if there are openings) for the next 6 months, or may be referred elsewhere.

5. Quest Center reserves the right to terminate a client due to continuous No-Shows/Cancellations.

Finding and Sustaining Recovery (FSR)

1. Attendance is required to all scheduled FSR services including assigned UAs, acupuncture, groups, and individual counseling sessions with their primary counselor.

2. Clients are also required to attend 3 outside support meetings per week, one of which must be a 12-step based meeting, unless discussed with and approved by FSR staff.

3. Absences are counted per FSR service, not day attended. If a client reaches 3 unexcused absences in one month, they are put on an attendance contract.

4. A contract involves homework and documentation of meetings attended and is reviewed typically in 30 days. Non-engagement of the contract may result in 14-day suspension from FSR services or in discharge from FSR programming.

Client Consent to Unsecure Electronic Messaging

The Quest Center for Integrative Health offers encrypted, secure options for communication via text messaging and email. These options require clients to download additional software to their personal device. While I am aware of these options, I, the undersigned, grant permission to employees of the Quest Center for Integrative Health to contact me via unsecured, unencrypted electronic mail (email) and text messaging (SMS) regarding my treatment at the Quest Center for Integrative Health. This includes all programs in which I am currently engaged or have engaged in the past at the Quest Center, such as naturopathy, acupuncture, alcohol and drug addiction treatment, mental health services, pain management, nutritional counseling, peer support services, and HIV services.

Communications from Quest Staff may relate to:

- The provision of medical treatment
- Health check-ups
- Appointments and reminders
- Lab test results
- Pre-operative instructions
- Post-discharge follow-up calls
- Notifications about prescriptions
- Home healthcare instructions
- Hospital pre-registration instructions

I hereby declare my full understanding of the following issues concerning unsecured, unencrypted electronic communication:

- Unsecured, unencrypted electronic communication is transmitted as plain text.
- The sender of electronic communication has no visibility of which networks a message passes through before reaching the recipient.
- Electronic communication is at risk of interception by third parties who have not been granted permission to view these communications.
- The content of unsecured, unencrypted electronic messaging can be opened and read by any third party which intercepts the message between sender and recipient as well as anyone who gains access to any device which is used to read and send messages between the intended sender and recipient.

I also declare my full understanding of the following:

- All communications between me and Quest staff may be made a part of my medical record. I have the same right of access to such communications as I do to the remainder of my medical record.
- If I choose not to install encryption software for sending and receiving emails and texts, the communication I send will not be secure, even if I receive secure, encrypted electronic communications from Quest staff.
- Backup copies of electronic communication may exist after the sender and/or recipient has deleted their copy.
- Electronic communications may be used as evidence in court.
- Quest is not responsible for any risk associated with me, the undersigned, experiencing a lost or stolen cellphone, computer, or other communication device, shared ownership of such a device, or a data breach unrelated to Quest.
- **In a medical emergency I should not text or email. I should call 911.**

_____	_____	_____
Client's Printed Name	**Client's Signature**	**Date Signed**

Medication Management Policy - Notice to Patients

PRESCRIPTIONS:

Refills for new patients:
For patients who need refills before their initial appointment with their prescriber: one month refills may be authorized, provided you have an upcoming scheduled appointment with the practitioner. If you do not show up for your first appointment, another refill will not be given until it has been approved after an in-person appointment with your practitioner.

Who will authorize prescriptions:
Medical prescriptions will only be authorized by our Medical practitioners.
Behavioral Health prescriptions will only be authorized by our Behavioral Health practitioners.
Behavioral Health practitioners will not authorize non- Behavioral Health prescriptions.

Transferring prescriptions:
To transfer your prescriptions or request a refill, please leave a voicemail with the medical assistant at 503-238-5203 Ext 200.

For each prescription please provide:

- Medication name
- Dosage: example: 40 mg
- Prescription directions: example: take 2 tablets (80 mg) daily at bedtime.
- Quantity: example: 30 pills for 30 days
- Pharmacy: example: Fred Meyer Pharmacy on N Interstate.
- Previous prescriber: example: Dr. Jane Doe

Refills for established patients:
Please call your pharmacy to request refills so they can fax the order to us. We will determine whether you need to come in for a follow up visit or blood draw, or whether there are other issues that may impact the refill.

We have a **3 business day** refill policy. For prescription refills, please be aware of the indicated number of refills left on your current prescription bottles and allow up to **3 business days** for your refill request to be processed. This means prescription refills called in on Friday will be approved by the following Wednesday.

If you stop receiving services at Quest or are discharged from Quest services:

If you are discharged or otherwise stop receiving services at Quest, please schedule with a new practitioner ASAP, within 30 days maximum. In most cases, we will continue to prescribe your medication until the date of your appointment, provided you have scheduled in a timely manner. However, for Behavioral Health clients who have already been discharged from services for more than 30 days, we may not be able to continue prescribing your medications

beyond 30 days after your discharge date. We are happy to fax your prescriptions to another practitioner once you have completed a Release of Information for them.

CONTROLLED SUBSTANCE PRESCRIBING:

Transferring controlled substance prescriptions:
Please provide accurate information regarding current prescriptions you would like transferred to Quest, including:

- Medication name
- Dosage: example: 40 mg
- Prescription directions: example: take 2 tablets (80 mg) daily at bedtime.
- Quantity: example: 30 pills for 30 days
- Pharmacy: example: Fred Meyer Pharmacy on N Interstate.
- Previous prescriber: example: Dr. Jane Doe

Please note: all previous prescriptions are recorded and will be retrieved from the Oregon Prescription Monitoring Program before any transferred prescriptions are refilled. If a question of misuse of controlled substances is indicated, the prescribing practitioner **will not** authorize any refills for the applicable prescription and a urine test may be requested, or an appointment will be required to explore alternative therapies.

Continuation of controlled substance prescription therapies are at the discretion of the practitioner. The practitioner may choose to change the prescription to a non-controlled substance therapy instead.

Urine tests:
For new patients for whom controlled substances are prescribed, a urine drug test may be requested at the discretion of the prescribing practitioner. To initiate and monitor adherence to certain drug therapies, urine tests may be requested by the practitioner at any time. Urine tests may be requested on a random basis, either same-day or scheduled, at the discretion of the practitioner, and patient compliance is expected.

QUESTIONS:
If you have questions/concerns **regarding your prescriptions** prior to your next visit, please contact our medical assistant at ext. 200 or email at: MA@quest-center.org. Please allow up to 3 business days for a response. **For urgent requests, please contact the front desk.** Please note that this is **only** for clarifications about your current prescriptions.

If there are new Medical issues you would like to address, or if you would like to have an extended discussion or modify your plan, please make an appointment for an office visit.

If you need to discuss Behavioral Health issues other than your current prescription, please contact your therapist or the Behavioral Health Administrative Specialist to have your call and/or concerns directed to the appropriate person.

Grievance Policy

Dear Quest Center Clients and Potential Clients,

You have a right to file a grievance (make a formal complaint). Your grievance will be kept confidential, except to the extent necessary to resolve the issue. No retaliatory action (ie. Dismissal/harassment, reduction in services/wages/benefits, basing service/performance review on the action) may be taken against you, any witnesses or staff member/provider assisting you and any grievance made in good faith is immune from civil or criminal liability. We wish to resolve the grievance at the lowest possible level and so encourage you to address any complaints to us first.

If you wish to file a grievance, please ask to speak with the QA/PI Committee Person (see below) or ask the front desk for a grievance form. The forms may also be found in the informational rack in the lobby, across from the restrooms. You may have a Quest Center representative of your choice help you complete the form.

Upon submission, your grievance will be reviewed by the QA/PI Committee. In most cases, the committee will meet and respond to your complaint within 5 business days. If more time is required to investigate and resolve the issue, a written notice will be sent to the individual who filed the grievance, extending the time up to 30 days and detailing the reason why. If you feel your grievance is urgent (may cause significant physical or mental harm if not addressed within 48 hours), you may indicate this on your form, or notify the QA/PI Committee Chairperson directly. The committee will respond to your urgent grievance within 48 hours.

You have the right to appeal grievance decisions by responding in writing within ten (10) working days of the date of the committee's response. The appeal must be submitted to the CMHP Director where the provider is located or to the division. You may have a Quest Center representative of your choice help you write the appeal. The CMHP Director or Division will respond in writing within ten (10) working days of the appeal. If you are not satisfied with this decision, you can file a second appeal in writing within ten (10) working days of the response from the Director or Division.

Quality Assurance/Performance Improvement Committee Chairperson: (503) 238-5203
Director, Mental Health & Addictions Services Division: (503) 988-5464
Disability Rights Oregon: (503) 243-2081 or (800) 452-1694
Health Systems Division, State of Oregon: (503) 945-5763
Governor's Advocacy Office: (503) 945-6904 or (800) 442-5238

Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities

YOU HAVE THE RIGHT TO:

▫Be treated with respect, courtesy, and dignity in a humane service environment with protection from harm and that affords reasonable privacy in a setting under conditions that are least restrictive to liberty, least intrusive to the client and which provides the greatest degree of independence

▫Be given information about mental health needs and treatment and have this information explained in a manner that is understandable to the member

▫Participate in choosing a provider

▫Refer oneself directly to a provider for covered services without first having to gain approval from another provider

▫Have access to covered services and obtain covered preventive services, which at least equals access available to other persons served by provider

▫Participate in planning and decisions about treatment including information about his/her condition and covered/non-covered services to allow an informed decision about proposed treatment(s)

▫Have a friend, family member, or advocate present during appointments and at other times as needed

▫Talk to providers and expect that what is said will be kept confidential

▫Have a clinical record maintained which documents conditions, services received, and referrals made

▫Have access to one's own clinical record, unless restricted by statute and to request that the record be amended or corrected as specified in 45 CFR part 164

▫Have a copy of his/her clinical record transferred to another provider

▫Get care without a long delay

▫Receive information about rights, responsibilities, benefits available, how to access services covered by the Oregon Health Plan and what to do in an emergency

▫Provide consent to treatment or refuse care and talk with provider about what this might mean

▫Receive necessary and reasonable services to diagnose the presenting condition

▫A second opinion, at no cost from a qualified healthcare professional within the network or outside the network if a qualified healthcare professional is not available

▫Know how to make a complaint or file a grievance about your provider and receive a timely response

▫Request a Department of Human Resources hearing, including an Expedited Hearing if they feel the problem is urgent or emergent and cannot wait for the normal hearing process

▫Request Continuation of Benefits until a decision in a hearing is rendered; however, the member may be required to repay any benefits continued if the issue is resolved in the favor of the provider

▫Receive mental health care regardless of age, race, religion, national origin, gender, or sexual orientation

▫Receive emergency mental health care 24 hours a day, 7 days a week

▫Change primary provider

▫Have someone to help talk to providers if language interpretation is needed, or are hearing or speech impaired at no cost to the consumer. An interpreter can be available during appointments.

▫To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation and have the freedom from abuse as defined in ORS 430.735 by an employee of Quest Center

▫Receive in writing, a 30-day notice in a readable format, when a service or benefit is cancelled reduced or changed. This is called a Notice of Action

▫Appeal when a service has been denied if they are the person consenting to treatment

▫Receive no services without written consent

▫Have adverse consequences of a service refusal explained verbally to me and my guardian if applicable

▫Not be terminated without being notified of available resources for continued services

▫Access and communicate privately with a rights protection program or advocate

▫To informed consent to fee-for-service

▫Receive materials in an alternate format appropriate to my needs

▫Receive gender appropriate services and/or culturally appropriate services

▫Receive notification of mandatory abuse reporting if there is reasonable cause to believe that I have suffered abuse

▫Receive services in compliance with the Americans with Disabilities Act

▫Receive a notice of an appointment cancellation in a timely manner

▫Execute a statement of wishes for treatment, including the right to accept or refuse treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990-Patient Self-Determination Act

▫Participate in the development of a written treatment 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 treatment plan

▫Have all services explained, including expected outcomes and possible risks

▫Not participate in experimentation

▫Receive medication specific to the individual's diagnosed clinical needs

▫Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation

▫Have religious freedom

▫Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule

▫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
▫Have family involvement in service planning and delivery
▫Make a declaration for mental health treatment, when legally an adult
▫Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules
▫Exercise all rights set forth in ORS 426.385 if the individual is committed to DHS
▫Exercise all rights described in this rule without any form of reprisal or punishment.

YOU HAVE THE RESPONSIBILITY TO:

- Choose a health provider
- Help provider get old health records or fill out new ones
- Honestly share concerns about health needs
- Ask questions about things that are not clear
- Help decide treatment plan and approve the plan before it starts
- Treat provider and staff with respect and courtesy
- Keep appointments and be on time. Call provider when late or can't keep the appointment.
- Bring your medical card/insurance card whenever care is needed
- Pay your monthly OHP Premium on time if so required
- Use only selected provider for mental health needs, in an emergency, services from someone else may be needed
- If emergency health services are used when out of the area; members must let your provider and insurance know within three days
- Tell provider if there are changes to address or phone number

These Member Rights and Responsibilities are in accordance with OAR 410-141-0320

Behavioral Health Individual Rights and Responsibilities 309-019-0115

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

a) Choose from available services and supports, those 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;

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 to receive a copy of the written service plan;

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.

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;

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;

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;

p) Have and opportunity to have family and guardian involvement in service planning and delivery;

q) Make a declaration for mental health treatment, when legally an adult;

r) File grievances, including appealing decisions resulting from the grievance;

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 request, 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.

Stat. Auth.: ORS 161.390, 413.042, 430.256, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 413.520 - 413.522, 426.380- 426.395, 426.490 - 426.500, 430.010,
430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200- 813.270

Behavioral Health Services

Mental Health

Quest Center's Integrative Mental Healthcare program serves adults, offering a comprehensive menu of evidence-based outpatient mental healthcare practices from a variety of disciplines. Our services are client centered, collaborative, and tailored specifically to meet and focus on individual needs and strengths.

Recognized for our warm and effective care, our licensed, credentialed, and experienced staff strives to develop a community that nurtures support, wellness, and self-empowerment.

The Integrative Mental Healthcare services are used widely throughout all of Quest's programs, and include:

- Assessments - $259
- Individual Therapy - $176 - $250
- Family/Couples Therapy - $176 - $250
- Group Therapy - $66
- Peer Support - $36 - $216
- Medication Evaluation - $194 - $301
- Medication Management $40 - $262
- Individual Therapy w Med Management - $198

Substance Abuse Treatment

Quest Center's Finding and Sustaining Recovery program is based on the belief that all people who want to can achieve a clean and sober life. Quest Center's supportive, nurturing and accepting community is key to aiding in people's recovery.

FSR is an abstinence-based alcohol and drug program that uses evidence-based approaches to develop and maintain clean and healthy lifestyles.

Each client undergoes a screening and assessment to determine what level of care is needed. Individual treatment plans are developed with each client.

This client-centered approach helps people to develop and support a culture and community of recovery through the following services:

- Assessments - $259
- Eligibility screening - $143
- Individual Therapy - $36 - $216
- Group Therapy - $66
- Case Management $28 - $168
- Peer Support $36 - $216
- Crisis Intervention - $36 - $216
- Group acupuncture - $44 - $81

If you are covered by the Oregon Health Plan and the above services are not covered by the Oregon Health Plan for any reason, you have the right to self-pay for these services. Applicable paperwork called an **Advance Beneficiary Notice (ABN form)** must be completed before services are provided. If you would like to learn how to proceed with self-pay options, please contact our Business Office at 503-238-5203. Quest Center requires that payment is made upon checking in for your appointment. Thank you.

Client Signature Page

By signing below, I agree that I have read fully and understand the terms and conditions outlined herein regarding the office policy and use and/or disclosure of health information. I understand and accept the policies listed in this agreement. I have reviewed and understand the permitted disclosures and give my consent to use my health information as named in the Acknowledgement, Consent, Confidentiality, Office Policy, and Rights and Responsibilities. I have asked questions about anything not clear to me, and I am satisfied with the answers I have received. I also certify that the information given to me is correct and I have read and consent to the terms of this policy, including payment for these services. I am the patient, or authorized as the patient's agent or representative to execute the above and accept the terms on behalf of the patient, and I assume individually all financial responsibility by signing below. I understand I may revoke this consent at any time.

Notice of Privacy Practices & Additional Rights

_____ I acknowledge that I have received a written copy of Quest Center for Integrative Health's Notice of Privacy Practices. I further acknowledge that this policy has been explained to me by my provider.

_____ I acknowledge that I have read and received a copy of Quest Center for Integrative Health's Client Rights and Responsibilities. I further acknowledge that this policy has been explained to me by my provider.

_____ I acknowledge that I have read and received a copy of Quest Center for Integrative Health's Client Consent to Unsecure Electronic Messaging. I further acknowledge that this policy has been explained to me by my provider

_____ I acknowledge that I have read and received a copy of Quest Center for Integrative Health's Grievance Policy. I further acknowledge that this policy has been explained to me by my provider.

_____ I acknowledge that I have read and received a copy of Quest Center for Integrative Health's overview of program services that are available and related fees when applicable. I further acknowledge that this policy has been explained to me by my provider.

_____ I acknowledge that I have discussed with my service provider and understand the risks and benefits of treatment.

Client's Printed Name	Client's Signature	Date Signed
Parent/Guardian's Printed Name	Parent/Guardian's Signature	Date Signed
Clinician's Printed Name	Clinician's Signature	Date Signed

Last Updated: 03/19/19