BestCare
Compassion Experience Recovery

New Patient Intake

CLIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Preferred Name: _____ **Date of Birth:** _____ **SSN:** _____

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

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

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Legal Sex: ☐ Female ☐ Male **Sex Assigned at Birth:** ☐ Female ☐ Male ☐ Intersex ☐ Unknown

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Questioning
☐ Non-binary/genderqueer ☐ Two Spirit ☐ Other: _____

Sexual Orientation: ☐ Straight/Heterosexual ☐ Bisexual ☐ Lesbian ☐ Gay ☐ Pansexual ☐ Queer
☐ Omnisexual ☐ Asexual ☐ Unsure ☐ Other: _____

Pronouns: ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ Client's name ☐ Other: _____

Race: ☐ White ☐ Native American ☐ Asian ☐ Alaskan Native ☐ African American
☐ Native Hawaiian ☐ Pacific Islander ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Preferred Language:** _____

Tribal Affiliation: ☐ Not applicable ☐ Tribe: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Significant Other

Veteran Status: Have you served in the US Military? ☐ Yes ☐ No

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Seasonal/Temporary
☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Other: _____

Housing Status: ☐ Not Homeless ☐ Homeless ☐ Living with Others ☐ Living in a shelter
☐ Transitional Housing ☐ Street, camp, bridge, vehicle

Do you live in public housing? ☐ Yes ☐ No **Have you applied for Medicaid/OHP?** ☐ Yes ☐ No

GUARANTOR

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

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

Primary Phone: _____ **Relationship to Patient:** _____

PRIMARY INSURANCE

Primary Insurance: _____ **ID:** _____ **Group #:** _____

Subscriber Name: _____ **Date of Birth:** _____ **Relationship to Client:** _____

SECONDARY INSURANCE

Secondary Insurance: _____ **ID:** _____ **Group #:** _____

Subscriber Name: _____ **Date of Birth:** _____ **Relationship to Client:** _____

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HEALTHCARE INFORMATION

Primary Care Provider: _____ **Office Name:** _____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Tobacco Use: ☐ Yes ☐ No ☐ Unknown **Substance Use during last 90 days?** ☐ Yes ☐ No ☐ Unknown

HOUSEHOLD INCOME

Estimated Gross Household Monthly Income: _____ **Family Size:** _____

Total Number of Dependents: _____ **Number of Child Dependents:** _____

Source of Income: ☐ Wages/Salary ☐ Public Assistance ☐ Retirement/Pension/SSI
☐ Disability/SSDI ☐ None ☐ Other: _____

ADDITIONAL SERVICES & SUPPORTS

Pregnant: ☐ Yes ☐ No ☐ Not applicable ☐ Unknown **Highest School Grade Completed:** _____

Would you like to register to vote? ☐ Yes ☐ No ☐ Already registered

Are you eligible or engaged with Intellectual & Developmental Disabilities (I/DD) services? ☐ Yes ☐ No

Do you have interest in employment with supports related to work (Supported Employment)? ☐ Yes ☐ No

LEGAL STATUS

Are you presently facing legal actions? ☐ Yes ☐ No (if yes, please explain) _____

DUII CLIENTS ONLY

ODL/ODI Number: _____ **Referred From:** _____

Number of arrests in the past month _____ **Total Arrests:** _____

Total DUII arrests in the past month _____ **Total DUII Arrests:** _____

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Communication Preferences & Permissions

Patient Name: _____ **Date of Birth:** _____

In order to protect the privacy and confidentiality of your information, please complete the following.

MESSAGES

☐ I give permission to BestCare to send text messages and/or leave messages on my voicemail regarding: *(select all that apply)*

☐ Appointments ☐ Billing ☐ Coordination of services

☐ Detailed clinical information, such as normal results, medication information or referral status

If applicable, messages can be left at the following number(s): _____

_____

☐ I give limited permission to receive messages that are only for appointment confirmations and location of services.

☐ I do not give permission for any messages to be left on my voicemail.

EMERGENCY CONTACTS

Emergency contacts are only contacted when clients experience an emergency. Minimal information will be given to emergency contacts.

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

☐ Decline to provide

AUTHORIZED CONTACTS

Authorized contacts are individuals you allow BestCare to communicate with regarding aspects of your care.

Name: _____ **Relationship:** _____ **Phone Number:** _____

☐ Manage appointments ☐ Communicate all information with my care team

Name: _____ **Relationship:** _____ **Phone Number:** _____

☐ Manage appointments ☐ Communicate all information with my care team

LEGAL DOCUMENTS

If the client has a legal representative, guardian, or medical power of attorney, please provide their name and legal documentation for our records. Clients who would like to complete a Declaration for Mental Health may inform a staff member and paperwork will be provided to them.

This authorization may be revoked in writing at any time. It will remain in effect until it is revoked or a new form is completed. I acknowledge that this document or its contents were provided to me in a language I understand.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Print Name of Person Signing this Authorization

_____ _____

If Signed by Legal Representative, Relationship to Patient **Date**

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Telehealth Services Consent

Client Name: _____ **Date:** _____

I consent to engage in telehealth services with BestCare's clinical staff and healthcare providers for the purpose of receiving medical and/or mental health care services.

I understand that telehealth involves the use of electronic communications to enable providers at different locations to share individual patient medical information for the purpose of improving patient care. Telehealth may include the use of video conferencing, audio communication, or other electronic communications.

Benefits and Limitations:
I understand that the benefits of telehealth services include the convenience of receiving care without having to travel to a physical location, increased access to healthcare services, and potentially lower costs. However, I also understand that there are limitations to telehealth services, including the potential for technological failures, interruptions in communication, and the inability for the provider to conduct a physical examination.

Privacy and Security:
I understand that the providers will take reasonable steps to ensure the privacy and security of my personal health information during telehealth sessions. However, I acknowledge that there are risks to privacy and security inherent in any electronic communication, including the potential for interception of data by unauthorized parties.

Emergency Situations:
I understand that telehealth services may not be appropriate for emergency situations. In the event of a medical or mental health emergency, I agree to immediately seek in-person care or call emergency services.

Alternate Forms of Communication:
I understand that I have the option to communicate with providers through alternative means, including in-person visits or telephone consultations.

Payment and Insurance:
I understand that payment for telehealth services may be required and that insurance coverage for telehealth services may vary. I agree to be responsible for any fees associated with telehealth services.

Consent:
By signing below, I acknowledge that I have read and understand the information provided in this consent form. I consent to participate in telehealth services with BestCare providers and agree to the terms outlined above.

_____ _____

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 1/01/2024

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
PLEASE REVIEW IT CAREFULLY.

BestCare Treatment Services, Inc. ("BestCare") creates a record of services you receive through our programs. While we are required to document the care you receive from us to fulfill legal requirements, we understand that health information about you is highly personal. Health information that identifies you includes your medical record and other information relating to your care or payment for services and is referred to as "protected health information" or "health information". BestCare is committed to protecting the privacy of health information we create or receive about you. Our guidelines for accessing your protected health information are in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 142, 160, 162, 164, and 42 CFR Part 2, which ensure only appropriate individuals have access to information on clients receiving mental health and addiction services.

This notice applies to:

- All divisions, facilities, and departments of BestCare
- All employees, staff, and other personnel at all BestCare locations
- Any health care professional authorized to enter information into your service record
- Any member of a volunteer group we allow to help you while you are a client of BestCare

OUR USES AND DISCLOSURES

How we typically use or share your health information.

Treatment	• We can use your health information and share it with other professionals who are treating you.
Payment	• We can use and share your health information to bill and get payment from health plans or other entities.
Health Care Operations	• We can use and share your health information to run our practice, improve your care, and contact you when necessary. ▪ We may disclose information about you to our business associates in order to carry out treatment, payment, or health care operations. ▪ BestCare may also disclose information to private accreditation organizations, including but not limited to the Commission on Accreditation of Rehabilitation Facilities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Public health and safety issues	• We can share health information about you for certain situations such as: ▪ Preventing disease ▪ Helping with product recalls ▪ Reporting adverse reactions to medications ▪ Reporting suspected abuse, neglect, or domestic violence ▪ Preventing or reducing a serious threat to anyone's health or safety
Research	• We can use or share your information for health research.

Comply with legal requests	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Organ and tissue donation requests	• If you are an organ donor, we can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation	• We can use or share health information about you for workers' compensation claims
Law enforcement	• We can share your health information for law enforcement purposes or with a law enforcement official **ONLY** in response to a judicial order • Information may be released in situations involving subpoenas, warrants, summons, or similar processes with a judicial order.
Health oversight and other government requests	• We may share your health information with health oversight agencies for activities authorized by law • Information may be released for special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Federal Confidentiality Requirements Under 42 CFR Part 2

Records from BestCare that fall under the Part 2 designation are protected as described in this notice. In accordance with 42 CFR § 2.22, the following is a written summary of the Part 2 regulations:

- Generally, a Part 2 Program may only acknowledge that an individual is present or disclose outside the Part 2 Program information identifying a patient as having or having had a substance use disorder in the following instances:
  - The patient's written consent is obtained in accordance with subpart C of Part 2,
  - An authorizing court order is entered in accordance with subpart E of Part 2,
  - The patient's records are disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency (42 CFR § 2.51),
  - The disclosure is for the purpose of conducting scientific research (42 CFR § 2.52), or
  - The disclosure is for the purpose of an audit or evaluation (42 CFR § 2.53).
- Violation of the federal law and regulations at Part 2 is a crime and suspected violations may be reported as follows:
  - Any violation of Part 2 may be reported to:

    BestCare Privacy Officer
    PO Box 1710, Redmond, OR 97756
    Phone: 541-668-8438 | Fax: 541-316-7422
    Email: compliance@bestcaretreatment.org

    United States Attorney
    Phone: 503-727-1000
    Email: usaor.webmaster@usdoj.gov
- If a patient commits a crime on the premises of the Part 2 Program or against personnel of the Part 2 Program, information related to the commission of that crime is not protected.
- Reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected.

YOUR RIGHTS

You have the following rights regarding your health information:

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Request to correct or amend your medical record	• You can ask us to correct or amend health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, if so, we will provide you with an explanation within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Request an accounting of disclosures	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures, except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another within 12 months.
Request a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• If you believe your rights have been violated, you may file a complaint by contacting: **BestCare Privacy Officer** PO Box 1710, Redmond, OR 97756 Phone: 541-668-8438 Fax: 541-316-7422 Email: compliance@bestcaretreatment.org • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ • **We will not retaliate against you for filing a complaint.**

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious,*

	we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to all BestCare Treatment Services programs and sites.

BestCare is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of BestCare, OCHIN supplies information technology and related services to BestCare and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by BestCare with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement."

BestCare Treatment Services

PO Box 1710

Redmond, OR 97756

Privacy Officer

Email: compliance@bestcaretreatment.org

Phone: 541-668-8438