CCMH consent to Treatment: Substance Use Disorder Services

Welcome to Columbia Community Mental Health (CCMH). This document will provide you with important information about what our services include, CCMH business practices, and will ask for your consent to our treatment program. CCMH works with a variety of providers including licensed medical professionals (MDs, PMHNPs, RNs), licensed clinical providers (LCSWs, LPCs), certified counseling program staff (QMHPs, QMHAs, CADCs, CGACs), and certified peer staff (PSS, PWS, CRMs). This list may not be exhaustive. All providers are authorized to provide care within the scope of their licensure and CCMH's own license. Any services you wish to receive is voluntary.

CCMH offers mental health, addictions and problem gambling related services. These services may be provided at various levels of care including time-limited (crisis), outpatient, intensive outpatient, respite, and residential services. By continuing with this informed consent you will first agree to and participate in an assessment with a trained clinician. Then, should you receive a diagnosis, you will be offered a recommendation for further treatment. You will have the right to provide input into the treatment planning process and your continued care experience.
CCMH may offer additional referrals to you outside the scope of our care based on our assessment, which you have a right to decline.

When you consent to treatment within CCMH your consent is considered effective until revoked in writing. This consent will apply to all CCMH sites, locations, and behavioral health services.

Telehealth:
I understand that telehealth is the practice of delivering behavioral health services via technology assisted media or other electronic means between a provider and a client, or group, who are located in different locations within the state of Oregon. CCMH offers in-clinic telehealth with providers off-site to expand our ability to serve a rural community. We also offer non-office based telehealth services to address barriers to in-clinic services and client convenience if eligible.
Session Disruption
I understand that I may experience issues with compatibility of technology or get disconnected. As a result, my provider will obtain a callback number to reach me should there be a disconnection. In the event of a technology breakdown, causing a disruption of the session, my provider will have a backup plan in place. If the technical issue cannot be resolved, your provider may elect to complete the session over the phone and may schedule future visits in-office if the problem is on-going.
Eligibility
CCMH is only able to provide telehealth services to clients located in Oregon where our clinicians hold valid OR state licenses and where we are licensed as an agency. Non-office based telehealth services may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit better from another form of service (e.g. face-to-face or in-office telehealth sessions), an appropriate recommendation will be made.

Transportation:

On a case-by-case basis and consistent to my assessed level of care needs, unique barriers, and individualized treatment plan, I may be offered transportation assistance. I understand and allow for CCMH to transport myself, or a person under my guardianship, in a vehicle. The person receiving transportation is expected to follow all applicable laws regarding riding in a motor vehicle and must follow all directions given to them by the driver for safety of all persons. I recognize that participation in this is voluntary and may result in personal injuries or death. I understand that I have the opportunity to decline transportation at any time without jeopardizing my treatment experience.

Mandatory Reporting:
I understand that all CCMH employees are mandatory abuse reporter and is required by law to notify appropriate authorities if they have reason to believe based on observation or interaction that I am an immediate risk of harm to self or others or if my provider has reason to believe a child or dependent adult (such as an older adult or person with a disability) is, or has been, in danger of physical, sexual, or emotional neglect or abuse.

Confidentiality:
I understand and have been offered a copy of CCMHs Notice of Privacy Practices and the privacy laws that protect the confidentiality of my protected health information apply to all areas of CCMH business operations. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. Technologies utilized by CCMH are compliant with CCMH policy, privacy and security standards of HIPAA, and the Oregon Health Authority's Privacy and Confidentiality Rules set forth in OAR 943, Division 14.
Ochin Collaborative
CCMH 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 CCMH, OCHIN supplies information technology and relates services to CCMH 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 asses 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 personal health information may be shared by CCMH with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purpose of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

The personal health information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

Communications:
In accordance with CCMH business operations, should I elect to provide a contact method, a CCMH employee may use this to contact me. This may include phone calls where I may be left a voicemail should I not be able to be

reached, text messages, email communications, and traditional mail delivery. If you wish to opt OUT of any of the below methods, please select below:

___ I do not consent to phone calls

___ I do not consent to have voicemails left for me

___ I do not consent to text messages

___ I do not consent to email communications

Program Documentation:
I understand that CCMH will make available to me at any time in my treatment records and information on how to create and record an advance directive, information on voting rights, information on my rights and responsibilities as a client of CCMH, and further information about any of our professional services.

Complaints:
I understand that I have a right to make a complaint against any employee of CCMH without retaliation or imapct to my treatment. Information about how to file a complaint will be made available to me by CCMH upon request, and if I need assistance completing a complain, CCMH employees will offer me help.

Client Rights and Responsibilities:
CCMH will give me access to a full copy of my rights and responsibilities as a client of CCMH. You have the right to have any information, including this document, provided to you in an alternative format, language, or other means that makes the information more accessible to you. I recognize that CCMH has the following policies and procedures that may impact my eligibility for treatment:

A. If I am more than 15 minutes late to any appointment, CCMH may cancel that appointment.
B. I am not allowed to bring any weapon onto CCMH property.
C. I am asked to reserve any smoking/vaping/etc for the appropriate smoking area. I may be asked to move away from doors, windows or other areas close to a CCMH building.
D. I am not to come to any appointment under the influence of a substance.
E. If I threaten, harass, or otherwise create a risk to the safety of CCMH's employees or other clients, I will be asked to leave. CCMH may take steps to mitigate further risk.
F. I am not to disclose any information about another person that I heard in group services provided by CCMH.
G. I have a right to have my service animal with me. If my service animal creates a direct threat or fundamentally alters the program, I may be asked to leave with my service animal.

Financial Agreement:
By requesting professional services from CCMH, I agree to a financial agreement to pay for them. CCMH will bill my insurance carrier prior to sending me any remaining balance. I understand that CCMH may not accept my insurance carrier, or my insurance carrier may not pay for the entirety of my services, and I will be responsible for any balance of my services. I will be asked for payment at the time of my appointment. Refusal of payment may result in the cessation of services. I may ask at any time for a copy of CCMH's fee schedule and information related to any potential balance on my account. If my insurance changes, I will notify CCMH at the earliest

opportunity. Failure to notify CCMH of an insurance change may result in being responsible for the full cost of the service.

Financial Assistance

CCMH offers a sliding scale fee discount program. I may request to be considered for a fee discount under this program. I will be asked for financial information to validate my eligibility. With this, CCMH may offer me reduced payment obligations. Under emergency circumstances, I may be eligible for a limited exception to fee collection should the withholding of services put me at direct threat of immediate harm.

Payment Plan

CCMH may offer an agreed upon payment plan. This plan would encompass a minimum agreed upon payment to be made monthly until the balance is paid in full.

Consent:

I consent to engage in services with CCMH. I understand that I have the right to withdraw consent to any such services at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled. I understand that CCMH may terminate eligibility to participate in services without affecting my right to future care, services, or program benefits to which I would be otherwise entitled to.

Please indicate the type of care you're are giving informed consent to:

___ Addictions and/or Problem Gambling Services

Signature:

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my consent to engage in treatment.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Description of Authority to Act for the Individual: _____