Welcome to Community Counseling Solutions. Enclosed you will find an Intake Packet. You will need to read and complete the entire packet before returning the forms to our office (an incomplete packet will delay processing through our office).

A Treatment Fee Agreement will be completed based upon your income and adjusted to an hourly rate. You are responsible for this fee at the time of each visit. If you are covered by the Oregon Health Plan-Plus, you are responsible for any applicable co-pay.

If you have any questions, please call the Boardman office at 481-2911, Heppner office at 676-9161, the Fossil office at 763-2746, the Condon office at 384-2666 or the John Day office at 541-575-1466.
COMMUNITY COUNSELING SOLUTIONS INTAKE FORM

Please complete form in pen, only

DATE:_________________________________

NAME:________________________________________

DID SOMEONE OR SOME PLACE REFER YOU HERE?

PRESENTING PROBLEM/REASON YOU ARE REQUESTING COUNSELING?

HAVE YOU BEEN SEEN BY COMMUNITY COUNSELING SOLUTIONS IN THE PAST?

YES                             NO

WHAT YEAR WERE YOU LAST SEEN BY COMMUNITY COUNSELING SOLUTIONS_________________________________

WHICH OFFICE WERE YOU SEEN  (Please circle one)

Heppner             Boardman            Fossil            Condon   Arlington   John Day

------------------------------------Office Use Only---------------------------------------------------

Assigned to: _________________________                        For:     Assessment
                                                        Primary Clinician

Assigned by: _________________________

Requested appointment date/time: _______________________________
COMMUNITY COUNSELING SOLUTIONS
APPLICATION FOR SERVICES

NAME:_________________________ MAIDEN NAME:___________________  DATE:_______________

DOB:________________________

MAILING ADDRESS:_____________________ PHYSICAL ADDRESS:___________________________

PHONE:_________________________ HOME   EMPLOYER NAME:___________________________

WORK

MARITAL STATUS:                            LIST DEPENDENTS IN HOUSEHOLD
Never Married ___   Married___     Name:               Age:        Relationship:
Separated___            Divorced___     ____________________________________
Widowed___        ____________________________________

Name of Spouse:_______________________   ____________________________________

Currently enrolled in school or training:  Yes/No   Race (optional)  White___  Black___
Highest Grade Completed: _________________   American Indian___  Hispanic___
Asian___  Other___

Name of Primary Doctor:________________________  Date Last Seen:______________________

Please list any Medications you are taking:_____________________________________________________

____________________________________

Reason(s) for Seeking Services:  Marital___               Alcohol___        Drug___  Mandated Evaluation___

       Child Guidance___ Personal___      Family___

Emergency Contact:__________________________________  Phone Number:_______________________

INSURANCE INFORMATION
Name of Insurance:_____________________________________ Phone Number:_____________________
Address of Insurance Co:________________________________
Name of Primary Insured:____________________________    Relationship:____________________________
ID#:_____________________________________  Group #:________________________________

I hereby consent to treatment by the personnel of Community Counseling Solutions.  I authorize payment directly to
Community Counseling Solutions for any services billed, but not to exceed the usual and customary charge for services.

______________________________________   ____________________________________
Witness        Consumer
COMMUNITY COUNSELING SOLUTIONS

ASSESSMENT FEE AGREEMENT

The cost of an assessment varies according to time spent with consumers and interviews with involved parties (family members, schools, physicians, referring agencies, etc). An adjusted hourly rate based on your gross monthly income and number of dependents, is available for those who cannot afford the full cost of services. If you are covered by private insurance, we must be allowed to bill your insurance in order for you to qualify for the sliding fee scale. You are responsible for payment of services at your sliding fee scale rate **AT THE TIME OF SERVICE.** The rate for ADES evaluation is set by the State of Oregon and is not eligible for sliding fee scale. **All fees will be due on the date the evaluation/assessment is completed.**

Gross Monthly Income $__________ Dependants (include yourself)_____

Source of Income____________________________________________________
(Wages, SSI, SSD, unemployment, pension, welfare, food stamps, child support, alimony)

Adjusted percentage of sliding fee scale_______%

Assessment in Clinic $_______ Assessment out of clinic $_______

_______ ADES evaluation $150.00

_______ ADES with Assessment $200.00

_______ Assessment due to ADES Referral $120.00

**I hereby agree to the fees set above.**

____________________________________  __________________________________
Consumer Signature      Consumer printed name

____________________________________
CCS Authorized Representative

Revised 4/09
COMMUNITY COUNSELING SOLUTIONS
TREATMENT FEE AGREEMENT

Initial Contract _______     Date_______________
Fee Renegotiation _______ 

Community Counseling Solutions is funded by client fees, insurance payments, and state dollars. An adjusted hourly rate, based on your gross monthly income and number of dependents, is available for those who cannot afford the cost of services. If you are covered by private insurance, we must be allowed to bill your insurance in order for you to qualify for the sliding fee scale. All DUII services are calculated at a flat rate. You are responsible for payment of services at your sliding fee scale rate/flat rate AT THE TIME OF SERVICE. Non-payment may result in no service.

Gross Monthly Income $______________   Dependents (include yourself) _______________
Source _______________________ (wages, SSI, SSD, unemployment, pension, welfare, food stamps, child support, alimony)

Adjusted percentage of sliding fee scale _____%

Services provided by Non-Medical Personnel
Assessment in Clinic $________ Assessment out of clinic $________
Individual Service in clinic $________/hr Individual Service out of clinic $________/hr
Group Service in clinic $________/hr Group Service out of clinic $________/hr
Peer Support $________/hr
Urinalysis $25.00 each Alcohol Screens $2.00 each
Comprehensive Multidisciplinary Team Service (children only) $________/hr

Services performed by Doctor, Psychiatrist, or Psychiatric Nurse Practitioner
Assessment in clinic $________ Assessment out of clinic $________
Individual Service in clinic $________/hr Individual Service out of clinic $________/hr

If the services provided to you are covered by the Oregon Health Plan Plus benefit package, you are responsible for any applicable co-payment at each appointment. The amount set in the above agreement only applies should your Oregon Health Plan Plus coverage lapse.

I hereby agree to the fees set above. I understand that should my financial circumstances change, the adjusted hourly rate can be renegotiated.

____________________________________  __________________________________
Consumer Signature        Consumer Printed Name

____________________________________
CCS Representative
Revised 04/09
CONSUMER RESPONSIBILITIES

As a client of this agency you are responsible for keeping appointments, paying fees, and complying with your treatment plan. If you are involved with the criminal justice system, you are expected to abide by any conditions that have been imposed.

This agency reserves the right to discharge clients who fail to meet these responsibilities. Threatening staff or another client with physical harm will not be tolerated and may be grounds for immediate termination from further treatment.

FEE AGREEMENT

At the time of your intake appointment, you will be charged an assessment fee. If you are covered under Oregon Health Plan Plus, you may be required to pay a co-pay at the time of service.

You will also be charged a fee for services. Fees will be based on “Clinic Cost” for one hour of treatment. An Adjusted hourly rate, based on your gross monthly income and number of dependents, is available for those who meet the income guidelines. If you are covered under Oregon Health Plan Plus, you may be required to pay a co-pay at the time of service.

FEE COLLECTION

Clients are responsible for payment of treatment at the time the service is rendered. Morrow/Wheeler County Behavioral Health will bill the following agencies:

- Oregon Health Plan
- Title XIX/Medicaid
- Third Party Insurance

In the event you assume all responsibility for the cost of services, you will be expected to pay for each individual or group session before the session begins. Failure to bring your payment may result in your termination from treatment as noncompliant and your referral back to the referring agency (Court, DHS, Parole and Probation, etc).

CANCELLATIONS/NO SHOWS

To assure success in your program, it is important that you attend every session. If for any reason you must miss a individual/group session, it is asked that you contact this agency and explain the reason for your absence.
ABSTINENCE/MEDICATION

In order to benefit from treatment, all participants are expected to refrain from the use of alcohol and other drugs. If you are referred to treatment as part of a Diversion Agreement, Oregon Administrative Rule mandates that you “**must demonstrate continuous abstinence for a minimum of 90 days prior to discharge as documented by urinalysis and other evidence.**” OAR 415-51-130(2). If you are found using alcohol or other drugs while enrolled in treatment, you may be terminated from treatment. If you come to the clinic under the influence of alcohol or other drugs, or refuse to submit to testing, you will be terminated from treatment. If a physician has prescribed any medication before or during your treatment, please notify your counselor of the type and dosage.

CONFIDENTIALITY

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by this agency. The agency may not say to a person outside the agency that a client attends the program, or disclose any information identifying a client UNLESS:
- The client consents in writing
- The disclosure is allowed by a court order, or
- The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

The agency is also prohibited from disclosing any information about a client’s actual or perceived HIV infection without specific written authorization signed by the client.

If you have been referred to treatment by the Oregon State Department of Human Service or as a condition of probation or parole, your counselor will ask you to sign a release which allows the agency to share the following information with DHS or Corrections:
- Use of alcohol or other drugs
- Attendance records
- New crimes

Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. (See 42 U.S.C. 290dd-3 and U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations.)
POLICY STATEMENT
COMMUNITY COUNSELING SOLUTIONS SERVICE

DESCRIPTION OF SERVICES:
Community Counseling Solutions is a private not for profit agency providing a variety of mental health services to Morrow, Wheeler, and Gilliam Counties. Such services include individual psychotherapy, marital therapy, family therapy, treatment of chronic mental illness, alcohol and drug problems, evaluation and assistance with mental retardation and mental disabilities, DUII Diversion and Convicted Education Treatment Program, evaluation and treatment of childhood problems, and comprehensive psychological evaluations. Psychiatric evaluations and medication monitoring is also available.

Community Counseling Solutions is supported by client fees, insurance receipts, and state and county dollars. Offices are located at 120 S. Main Street, Heppner, Oregon; 101 NW Boardman Avenue, Suite A, Boardman, Oregon; 401 4th Street, Fossil, Oregon; 422 N Main, Condon, Oregon, 120 Arlington Mall, Arlington, Oregon, and 528 E Main, Suite W John Day, Oregon. Twenty-four (24) hour emergency coverage is available by dialing 911.

ELIGIBILITY:
Community Counseling Solutions provides services to all clients, regardless of race, religion, sex ethnicity, age, handicap, sexual preference, place of residence, or ability to pay for services. The charges for services are based on income and ability to pay.

CONSUMER RIGHTS:
Communications between clients and clinicians are confidential to the extent that Community Counseling Solutions will not disclose identifying information or content of the communications to private parties without the written consent of the client.

Community Counseling Solutions may break confidentiality and disclose information about a client in certain situations if: 1) The client is judged, by the clinician, to pose an immediate danger to self or others, 2) Such information is necessary to meet a medical emergency involving the client, 3) The clinician has reason to believe the client is physically or sexually abusing children or is a child being abused, or 4) The client is a minor less than 14 years of age.

Clients may review their own records in the presence of the clinician. Clients may be provided with written summaries of their records on written request.

You have the right to execute a “Declaration of Mental Health Treatment” which affords you the opportunity to plan for a time when you may be unable to make your own mental health treatment decisions.

You have the right to request, in writing, a change of clinician. The supervisor will review the request and an accommodation may be made.

GRIEVANCE PROCEDURE:
Should a client become dissatisfied with treatment for any reason, a formal grievance may be submitted in writing to the Program Manager. The Program Manager will respond within three working days from receipt of the grievance. If the client is not satisfied with the results of this action she/he may appeal to the Executive Director. The Executive Director will respond in writing to the client within five working days. If the client feels the issue has not been resolved to their satisfaction, the client may appeal to Community Counseling Solutions’ Advisory Board. If the results remain unsatisfactory to the client they may seek the assistance of the Oregon Mental Health Division. If at any time during this process the client would like the help of a consumer advocate, the CCS will assist in securing an independent advocate.

Any questions concerning the information stated above should be addressed to the Program Manager, Community Counseling Solutions, P.O. Box 469, Heppner, Oregon 97836.

I consent to treatment at Community Counseling Solutions under the conditions stated above.

__________________________________________________________________________
Consumer’s Signature                                                                 Date
AUTHORIZATION OF
COMMUNITY COUNSELING SOLUTIONS (CCS)
TO DISCLOSE and EXCHANGE HEALTH INFORMATION

Consumer's Name: ________________________________
(OR CHILD) Last    First    Middle

Date of Birth: __________________________________

MY HEALTH INFORMATION:
I agree to the disclosure of the following health information to:

Office of Mental Health and Addiction Services
500 Summer St NE E86
Salem, OR  97301-1118

SPECIFIC INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes (Please initial appropriate line):

___Information about treatment or evaluation of a Mental Condition being provided to other than a cooperating provider for treatment or diagnosis, which includes:
  * Program Assignment & Dates of Service
  * Demographic Information
  * Income/Health Insurance
  * Employment Status
  * Academic Improvement information on Children
  * Crisis Information
    (petition info, hearing info, case disposition, basis for commitment)

___Information about treatment or evaluation of alcohol or drug abuse treatment program services, which includes: (Note, names are coded when sent to state, so this info is non-identifying)
  * Program Assignment & Dates of Service
  * Demographic Information
  * Income/Health Insurance
  * Employment Status
  * Arrests
  * Termination Type
  * Urinalysis Results

___Information about Developmental Disabilities program services, which includes:
  * Program Assignment & Dates of Service
  * Disability Characteristics
  * Income/Health Insurance
  * Eligibility Codes

TERM: This authorization to remain in effect until treatment completion and chart closure.

PURPOSE: I authorize CCS to use or disclose my health information (including the highly confidential information I selected above,) during the term of this Authorization for the following specific purpose(s):

Document services provided by state and federal funds, performance data, research, performance evaluation, gun control verification
This information is required by the State of Oregon for any consumer who receives services at Community Counseling Solutions through the use of public funds. This includes those consumers covered by the Oregon Health Plan and those who utilize the sliding fee scale and have their fees subsidized.

I understand that if I do not want to sign this authorization, I may refuse to do so. And, if I do sign this Authorization and change my decision regarding disclosure of this information, I may revoke (withdraw) my authorization. If I decide to revoke my authorization, I will notify staff at CCS, who will provide me with a Revocation Form, or I will send a signed written notice to CCS. If I refuse to sign or revoke my authorization, it will not affect the provision of treatment by CCS.

If I submit a written request to CCS to inspect and/or obtain a copy of my health information, CCS will, within five (5) working days, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial. The response to the request will also provide review rights (if any), and instructions as to how and with whom a complaint can be filed regarding the denial.

This Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to CCS's Privacy Office at the address listed below. The revocation will be effective immediately upon CCS's receipt of my written notice. Revocation of this Authorization will not have any effect on any action already taken by CCS before it received my written notice of revocation.

I may contact CCS’s Privacy Office by mail at Community Counseling Solutions, P.O. Box 469, Heppner, OR 97836, or by telephone at (541) 676-9161.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize CCS to use or disclose my health information in the manner described above.

Signature of Consumer __________________________ Date __________

Note: If the Consumer is under the age of fourteen at the time of the request for disclosure or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Authorized __________________________ Relationship __________ Date __________
Personal Representative to Patient

To The Recipient:

Mental Health Information:
Except as otherwise permitted by law or authorized by the individual to whom this health information pertains, re-disclosure of this information to another party is PROHIBITED by state law, ORS 179.505.

Alcohol and Drug Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”
COMMUNITY COUNSELING SOLUTIONS

NOTICE OF PRIVACY PRACTICES

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.

We are Community Counseling Solutions, (CCS) and this Notice describes our privacy practices. These practices are applicable to all six of our locations, Boardman, Heppner, Fossil, Condon, Arlington, John Day, and to all staff, including administrations, clinicians, case managers, and support staff.

OUR PRIVACY OBLIGATIONS

As required by law, we will maintain the privacy of your health information (also referred to as “Protected Health Information” or “PHI”). This Notice is a statement of our legal duties and privacy practices. If we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice.

I. PERMISSIBLE USES and DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION.

Certain kinds of PHI receive special protection by either state or federal law, this health information involves mental health, chemical dependency treatment, HIV/AIDS testing, child abuse and neglect, sexual assault, and genetic testing. Therefore, PHI involving this type of information will not be disclosed to outside providers without your specific written authorization (“Your Authorization”). However, we may use and disclose your PHI without Your Authorization for the following purposes:

Treatment, Payment and Health Care Operations. We may use and disclose PHI, in order to treat you, obtain payment for services provided to you and conduct our health care operations as detailed below:

• Treatment. We use and disclose your PHI to provide treatment and other services to you—for example, to diagnose and treat your condition. In addition, unless you object, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.

• Payment. We may use and disclose your PHI to obtain payment for services that we provide to you from the Oregon Health Plan, Greater Oregon Behavioral Health, Inc. (GOBHI) or a governmental program that arranges or pays the cost of some or all of your health care. We will obtain Your Authorization to disclose PHI to your private health insurer, HMO or other private insurer.
• **Health Care Operations.** We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our social workers and other health care workers. We may disclose PHI to the Director or Assistant Director or a staff person in order to resolve any complaints you may have and ensure that you have a comfortable visit with us.

**In addition to the above operational activities, there are a number of areas in which we may share your PHI without your authorization and as required by law, they are:**

**Public Health Activities.** We may report to:
1. public health authorities to prevent or control disease, injury or disability;
2. report child abuse or neglect to the Oregon Department of Child Welfare
3. report information about products and services to the U.S. Food and Drug Administration;
4. to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and
5. to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

**Victims of Abuse, Neglect or Domestic Violence.** If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to the Oregon Department of Children and Family Services, the Oregon Department of Human Services or other governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

**Health Oversight Activities.** We may disclose your PHI with government oversight agencies charged with responsibility for ensuring compliance with the rules of government health programs, such as Medicare or Medicaid.

**Judicial and Administrative Proceedings.** We must disclose PHI in response to a legal order or other legal proceedings.

**Law Enforcement Officials.** We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

**Decedents.** We may disclose your PHI to a coroner or medical examiner as authorized by law.

**Organ and Tissue Procurement.** We may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

**Health or Safety.** We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person’s or the public’s health or safety.

**Specialized Government Functions.** We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.
**Workers’ Compensation.** We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

**As required by law.** We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

II. USES and DISClosures REQUIRING YOUR WRITTEN AUTHORIZATION.

For any purpose other than the ones described above in Section I, we only may use or disclose your PHI when you give us Your Authorization on our authorization form.

**Your Family or Friends Involved with Your Care.** Your family or friends involved with your health care may request your PHI, however, unless they are your representative, or you sign an authorization permitting us to do so, we will not give out the information.

**Information Required for Private Insurance Payment.** We will not disclose PHI to your private insurer unless you sign an authorization permitting us to do so. However, if we are unable to obtain payment due to a lack of information, you will be financially responsible for the payment.

**Uses and Disclosures of Your Highly Confidential Information.** In addition, federal and Oregon law imposes special privacy protections for Psychotherapy Notes and the subset of Protected Health Information that is related to: (1) treatment of a mental illness; (2) alcohol and drug abuse treatment program services; (3) HIV/AIDS testing; (4) child abuse and neglect; (5) sexual assault; and (6) genetic testing.

III. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

**For Further Information; Complaints.** If you desire further information about your privacy rights, or if you think that we have violated your privacy rights or you disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

**Right to Request Additional Restrictions.** You may request additional restrictions on our use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from a CCS staff person and submit the completed form to the Privacy Officer. We will send you a written response.

**Right to Receive Confidential Communications.** You may request, and we will accommodate, any reasonable written request for you to receive your contact with us or PHI by alternative means of communication or at alternative locations. If you do not wish to have messages from us left at your residence or place of work, please submit a written request.
**Right to Revoke Your Authorization.** You may revoke Your Authorization, however any actions we have already taken in reliance upon your authorization will be considered authorized. If you wish to revoke an authorization, send a written revocation statement to the Privacy Officer identified below.

**Right to Inspect and Copy Your Health Information.** You may request to review and copy your medical and billing records that we maintain in a designated record set. Oregon Law requires that we respond to you within five (5) working days. Under limited circumstances, we may deny you access to a portion of your records. If you would like to review your records, please request a form from a CCS staff person and submit the completed form to the staff person or the Privacy Officer. If you request copies, we will charge you for each page according to the current Morrow County copy fee rate. We will also charge you for our postage costs, if you request that we mail the copies to you.

**Right to Amend Your Records.** You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Officer and submit the completed form to the Privacy Officer. We will comply with your request unless we believe that the information that you are asking to be changed is accurate and complete or other special circumstances apply.

**Right to Receive An Accounting of Disclosures.** Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request, provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we may charge you for the accounting statement.

Upon request, you may obtain a paper copy of this Notice.
This notice is effective: April 14, 2003

We may change the terms of this Notice at any time, however, if we do so, we will make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas of Community Counseling Solutions. You also may obtain any new notice by contacting Community Counseling Solutions, and asking for the Privacy Officer.

If you have questions or complaints, you may contact the Privacy Officer by writing or calling:

Privacy Officer
Community Counseling Solutions
P.O. Box 469
Heppner, Oregon 97836
Telephone: (541) 676 – 9161
COMMUNITY COUNSELING SOLUTIONS

ACKNOWLEDGEMENT of NOTICE OF PRIVACY PRACTICE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review and ask questions about our notice before signing this acknowledgement. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by asking for one at any of our offices.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing below, you acknowledge receipt of COMMUNITY COUNSELING SOLUTIONS’ Notice of Privacy Practices.

________________________________________  ___________________________________________
Signature of Consumer         Relationship to Consumer
(Or Personal Representative)

________________________________________  ___________________________________________
Printed Consumer Name         Date

**If consumer or personal representative is unable to sign this acknowledgement form, or refuses to sign, explain circumstances below.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________  ___________________________________________
Signature of CCS Staff         Date
Would you like to register to vote at our agency?

Yes_______
No_______

Signature__________________________________________
Date______________________________________________

Office Staff: Please initial when completed

_____Registration form given to consumer.

_____Registration information sent to Heppner.