SALEM PSYCHIATRIC ASSOCIATES
Valley Mental Health
821 Saginaw St. S Salem, OR 97302
TEL (503) 589-4046
FAX (503) 480-0484
www.salempsych.com
www.valleymental.com

SPA/VMH PATIENT POLICIES PACKET

Contents

SIGNATURES REQUIRED AT INTAKE FOR POLICES HIGHLIGHTED IN YELLOW

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Full Legal Name: _____ DOB (MM/DD/YYYY): _____

INFORMED CONSENT TO TREATMENT

At Salem Psychiatric Associates and Valley Mental Health, your treatment may be provided by a subcontracted provider and/or at a satellite office. As such, any physician or therapist associated with Salem Psychiatric Associates and Valley Mental Health may review your records in part or in whole. Otherwise, clinical records are kept under the strictest rules of confidentiality, which means that information about your treatment will not be released to any outside agency or individual without your written permission. Please be advised, however, that rules of confidentiality will be broken under certain circumstances as SPA/VMH employees and subcontractors are required by law to report evidence of suicidal or homicidal intent, evidence of past or current child abuse and evidence of past or current elder abuse. Additionally, confidentiality may be broken if the information we have could help save your life in a life- threatening emergency. If you have questions about confidentiality, please feel free to discuss them with your provider.

Entering mental health treatment is a courageous step. You should know that sometimes symptoms become worse before they become better, though this should subside as the work of treatment progresses. Your provider may ask you to participate in activities or ask you to do tasks outside the time you meet with your provider. While you have the right to refuse any therapeutic technique, we must be able to discuss your thoughts and feelings about your treatment. You will be involved in the process of designing and implementing, and the periodic review, of your Treatment Plan. If you have any questions about the nature of your treatment, talk directly to your provider as soon as the question arises.

Regarding Therapy Services I understand that sometimes symptoms become worse before they become better, though this should subside as the work of treatment progresses. have the right to refuse any therapeutic technique. I understand that refusing to follow my therapist's recommendations or discuss my feelings about treatment may negatively impact my progress and may lead to a termination of services. I will receive an assessment and diagnoses from a Qualified Mental Health Professional. I will be involved in the process of designing, implementing, and the periodic review of my Individual Service Plan. I will talk directly to my therapist if I have any questions about the nature of my treatment.	Initial Here
Regarding Medication Management Services I understand that at any time during my time at Salem Psychiatric Associates and Valley Mental Health, my prescriber has the right to mandate a therapist as part of my treatment plan, and I will have 90 days to obtain a therapist and actively attend sessions. I understand that I will be required to fill out a release of information so my medication prescriber may coordinate care. Failure to meet these requirements may result in a loss of medication services. I will receive an assessment and diagnoses from a Qualified Mental Health Professional. I will be involved in the process of designing, implementing, and the periodic review of my Individual Service Plan. I will talk directly to my prescriber if I have any questions about the nature of my treatment.	Initial Here
I understand that after the initial appointment (known as the intake) the provider reserves the right to not continue in a client/provider relationship and I will be offered community resources to obtain care elsewhere if they feel that they will not be a good fit.	Initial Here

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INFORMED CONSENT FOR TREATMENT

I understand that my **health information** may include information both created and received by SPA/VMH, 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, hospital or emergency department visits and similar types of health-related information.	Initial Here
I understand and agree that SPA/VMH may **use and disclose** my health information to: • Make decisions about and plan for my care and treatment. • Refer to, consult with, coordinate among, and manage along with other health care 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 for paying for some or all my healthcare. • Perform various office, administrative, and business functions that support my provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.	Initial Here
I also understand that I have the right to receive and review a written description of how this practice 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 this practice, and my rights regarding my health information.	Initial Here
I have been offered a copy of this **Informed Consent to Treatment.**	Initial Here
I have been offered a copy of and understand the **Notice of Privacy Practices** that details how and when confidential information may be shared by Salem Psychiatric Associates and Valley Mental Health.	Initial Here
I understand that any electronic information that I share with my treatment provider may not be secure and does not comply with HIPAA standards. All exchanges, including copies or summaries of email and text message exchanges, may be maintained in my file according to state regulations governing mental health records. I also understand that the decision to use any form of electronic communication is up to the discretion of my assigned provider. Electronic formats should not be used to communicate emergency information.	Initial Here
I have been offered a copy of my Rights and Responsibilities	Initial Here

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INFORMED CONSENT FOR TREATMENT

I have been offered a copy of and will follow the Grievance Procedure if I have any concerns or complaints about the services I receive at VMH.	Initial Here
I was offered and/or completed a Declaration for Mental Health Treatment	Initial Here
I was offered a copy of and instructed about my right to have a Medical Advance Directive	Initial Here

Note: Individuals 14 years or older must provide written consent to treatment unless a court or other law authorizes someone other than the individual and/or parent to make treatment decisions (ORS 109.675)

SIGNATURE: _____ **DATE:** _____

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SERVICE ANIMAL POLICY AND AGREEMENT FORM

☐ **I do not have a service animal.**

Salem Psychiatric Associates and Valley Mental Health honors and respects the rights of individuals who have service and therapy animals, including animals to assist those with disabilities and animals that provide emotional support.

A **Service Animal** is one that performs tasks to assist a person with a disability. Other names for these animals include guide animal, hearing animal, mobility animal, medical alert animal, and psychiatric service animal. Your rights regarding service animals are protected under the Americans with Disabilities Act (ADA).

A **Therapy Animal** provides therapeutic support to an individual with mental health concerns. Other names for these animals include emotional support animals, companion animals, or comfort animals.

If you plan to bring your **service animal** with you to your appointments, please fill out the information below. Please note that to protect the therapeutic atmosphere and the rights of all SPA/VMH clients, any animals that exhibit aggressive or disruptive behaviors will not be allowed on the premises.

Please list the following information for your service animal:

1. **Animal Name:** _____
2. **Type of Animal:** _____
3. **Type of service/task performed by the service animal:**

I certify that I have read and understand the service animal policy.

Note: Individuals 14 years or older must provide written consent to treatment unless a court or other law authorizes someone other than the individual and/or parent to make treatment decisions (ORS 109.675)

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INFORMED CONSENT FOR USE OF ARTIFICIAL INTELLIGENCE (AI) TOOLS

Salem Psychiatric Associates and Valley Mental Health (SPA/VMH) may use secure, HIPAA-compliant artificial intelligence (AI) tools to support certain administrative and clinical tasks. Examples may include: assisting with documentation, organizing information, or helping providers stay current with best practices. AI tools do not replace professional judgment or therapy, and your provider remains fully responsible for your care and all clinical decisions.

You have the right to:

1. Be informed when AI tools are used in your care.
2. Ask questions about how these tools support your treatment.
3. Decline the use of AI in your care, when feasible, without impact on access to services

Note: Individuals 14 years or older must provide written consent to treatment unless a court or other law authorizes someone other than the individual and/or parent to make treatment decisions (ORS 109.675)

SIGNATURE: _____ **DATE:** _____

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OHP FEE AGREEMENT

I, _____ (please print first and last name), acknowledge that I have read and had the opportunity to ask questions about and understand the following:

Clients with active Oregon Health Plan (OHP)/Medicaid insurance will not be billed for any services, missed appointments, copays or coinsurance.

Clients without health insurance will be responsible for payment in full for all services provided. Payment is due at the time of service unless other arrangements have been made in advance.

SESSION FEES POLICY ACKNOWLEDGEMENT FORM

I, _____ (please print first and last name), acknowledge that I have read, had the opportunity to ask questions about, and understand the following policies related to my care at Salem Psychiatric Associates and Valley Mental Health:

Cancellation Policy: My appointment time is reserved specifically for me. If I cannot attend, I must cancel at least 48 hours in advance to avoid a charge. If I cancel less than 48 hours before the appointment or fail to attend **and do not have Oregon Health Plan (OHP)/Medicaid insurance**, I will be charged a $100 fee. Please refer to the Session Fees section for more information about scheduling appointments only after outstanding balances are paid.

Office Fees: Our office fees vary depending on the services provided. I have received a handout detailing the SPA/VMH charges and procedures. If not, I will request one.

Insurance Billing: If I have acceptable insurance coverage, the office will gladly bill my insurance as a courtesy. However, I understand that if I do not have OHP insurance at the time of my appointment I am responsible for full payment for appointments, regardless of my insurance coverage.

Monthly Statements: I will receive monthly statements outlining any outstanding balances and will be mailed to the address listed in my chart. These statements will ensure transparency and keep me informed of any amounts due. I understand that I will need to contact the office if I do not want to receive a statement.

Payment Due Dates: All fees, co-pays, co-insurances, and deductibles are due at the beginning of each month for the previous month's services.

Fee Schedule: The SPA/VMH Fee Schedule can be accessed at www.valleymental.com/feeschedule

- **Payment Options:** We offer several payment methods for both in-office and virtual appointments:
  - You can keep a credit card on file for automatic payments.
  - You can pay online through your MYIO Patient Portal.
  - You can make a payment over the phone by calling our Billing office at (503) 877-2216

  Outstanding Balances: If I have an unpaid balance, future appointments will not be scheduled until payment is made.
  - To schedule a new appointment, I can make a payment over the phone at (503) 877-2216
  - Prompt payment will ensure uninterrupted medication management during my appointments.

Payment Arrangements: If I need to make payment arrangements due to special circumstances, I will contact the billing office prior to receiving treatment. Addressing financial matters in advance will help ensure the smooth continuation of my care.

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SESSION FEES POLICY ACKNOWLEDGEMENT FORM CONTINUED

Additional Fee Policies:

- There is a $25 charge for any returned checks.
- Unpaid balances will incur a 2% interest charge per month once past due.
- If there is no payment plan in place and no payments are received after 3 months, my account may be referred to a collection agency.

I acknowledge and agree to the above policies to support my treatment at Salem Psychiatric Associates and Valley Mental Health

To be signed by the individual responsible for all charges not covered by insurance:

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CLIENT: _____

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AUTOMATIC PAYMENT AGREEMENT

Would you like to keep a credit card on file for automatic payments? ☐ Yes ☐ No

If no: I understand that I have the option to leave a card on file and I currently **DECLINE**: _____
(initial here)

If yes:

I, _____ (cardholder name), authorize Valley Mental Health to charge my credit card on file for the out-of-pocket expense for any visit(s) with the patient's provider.

I understand that it is my responsibility to ensure that Valley Mental Health has an accurate and up-to-date credit card on file for automatic payments: _____
(initial here)

I understand that my card will be run on the first week of each month for any amount due for any visits from the previous month: _____
(initial here)

To be signed by the individual responsible for all charges not covered by insurance:

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CLIENT: _____

INDIVIDUAL RIGHTS AND RESPONSIBILITIES

As an individual receiving services from Salem Psychiatric Associates and Valley Mental Health, you have the right to:

- Choose from available services and supports, those are consistent with the 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.
- Be treated with dignity and respect.
- Have access to Peer Delivered Services.
- Participate in the development of a written Service Plan, receive services consistent with that plan, and participate in the 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.
- Have all services explained, including expected outcomes and possible risks.
- 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.
- 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 circumstance:
    - Under age 18 and lawfully married
    - Age 16 or older and legally emancipated by the court; or
    - Age 14 or older for outpatient services only. For purposes of informed consent, outpatient services do not include service provided in residential programs or in day or partial hospitalization programs.

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INDIVIDUAL RIGHTS AND RESPONSIBILITIES CONTINUED

- Inspect your Service Record in accordance with ORS 179.505.
- Refuse participation in experimentation.
- Receive medication specific to your diagnosed clinical needs.
- Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety.
- Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation.
- Have religious freedom.
- Be free from seclusion and restraint.
- 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 present.
- Have family and guardian involvement in service planning and delivery.
- Make a declaration for mental health treatment, when legally an adult.
- File grievances, including appealing decisions resulting from the grievance.
- 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 the Authority; and
- Exercise all rights described in this rule without any form of reprisal or punishment.

Salem Psychiatric Associates and Valley Mental Health must give you and, if appropriate, your guardian, a document that describes your rights as follows:

- Information given to you must be in written form or, upon request, in an alternative format or language appropriate to your needs.
- The rights, and how to exercise them, must be explained to you, and if appropriate, your guardian; and
- Your individual rights must be posted in writing in a common area.

To be signed by the individual responsible for all charges not covered by insurance:

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CLIENT: _____

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NO SHOW/LATE CANCELLATION POLICY

Please note: your appointment time is reserved just for you. We respect your time and we do not double-book our patients. Therefore, we require **48 hours' notice** if you need to change or cancel your appointment so that the time may be offered to someone else in need. Salem Psychiatric Associates and Valley Mental Health understand that sometimes missed appointments can mean that someone is not yet ready for treatment. If this is the case for you, our intake department and providers are happy to support you in coming back into services when the time is right.

For changes to a therapy appointment, please contact your therapist directly.
For changes to a medication or case management appointment, please call **(503) 589-4046.**

1. Appointments must be cancelled or rescheduled 48 hours before the appointment to allow scheduling for other individuals.

2. After the **FIRST UNEXCUSED MISSED APPOINTMENT,** a new appointment may be scheduled within 14 days or the first available time that works for your provider. **FOR MISSED MEDICATION APPOINTMENTS,** a limited amount of medication will be prescribed until the new appointment can be scheduled.

3. After the **SECOND UNEXCUSED MISSED APPOINTMENT,** a warning letter will be mailed out that reminds the individual that ALL services are at risk of being discontinued. Individuals can also be offered a referral to a general case manager to identify obstacles to accessing care that can be addressed, if needed.

4. After the **THIRD UNEXCUSED MISSED APPOINTMENT,** your provider and/or prescriber may choose to discontinue services and, if so, will mail you a Service Conclusion Letter. If **MEDICATION SERVICES** are discontinued, you will be prescribed enough medications for one month and referred to your Primary Care Provider or to PacificSource Community Solutions (CCO) for a new prescriber.

Unexcused missed appointments are defined as any "No Shows" or appointments cancelled outside the 48-hour time frame that have not been approved by the therapist, assigned prescriber, or case manager. When appropriate, Salem Psychiatric Associates and Valley Mental Health reserves the right to request documentation for any missed appointment due to a health or safety concern.

To be signed by the individual responsible for all charges not covered by insurance:

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CLIENT: _____

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ATTENDANCE POLICY

Please note: your appointment time is reserved just for you. We respect your time and we do not double book our clients. Therefore, we require **48 hours' notice** if you need to change or cancel your appointment so that the time may be offered to someone else in need. Salem Psychiatric Associates and Valley Mental Health understands that sometimes missed appointments can mean that someone is not yet ready for treatment. If this is the case for you, our intake department and providers are happy to support you in coming back into services when the time is right.

For changes to a therapy appointment, please contact your therapist directly.
For changes to a medication or case management appointment, please call **(503) 589-4046.**

All appointments must be cancelled or rescheduled 48 hours before the appointment to allow scheduling for other individuals.

If you are a **NEW THERAPY OR MEDICATION CLIENT** and your intake is considered an **UNEXCUSED MISSED APPOINTMENT**, your provider may choose not to reschedule with you, and we cannot guarantee that we will have another provider available to work with you.

For established SPA/VMH Clients:

1. After the **FIRST UNEXCUSED MISSED APPOINTMENT,** a new appointment may be scheduled within 14 days or the first available time that works for your provider. **FOR MISSED MEDICATION APPOINTMENTS,** a limited amount of medication will be prescribed until the new appointment can be scheduled.

2. After the **SECOND UNEXCUSED MISSED APPOINTMENT,** a warning letter will be mailed out that reminds the individual that ALL services are at risk of being discontinued. Individuals can also be offered a referral to a general case manager to identify obstacles to accessing care that can be addressed, if needed.

3. After the **THIRD UNEXCUSED MISSED APPOINTMENT,** your provider and/or prescriber may choose to discontinue services and, if so, will mail you a Service Conclusion Letter. If **MEDICATION SERVICES** are discontinued, you will be prescribed enough medications for one month and referred to your Primary Care Provider or to PacificSource Community Solutions (CCO) for a new prescriber.

Unexcused missed appointments are defined as any "No Shows" or appointments cancelled outside the 48-hour time frame that have not been approved by the therapist, assigned prescriber, or case manager. When appropriate, Salem Psychiatric Associates and Valley Mental Health reserves the right to request documentation for any missed appointment due to a health or safety concern.

I certify that I have read and understand the attendance policy.

Note: Individuals 14 years or older must provide written consent to treatment unless a court or other law authorizes someone other than the individual and/or parent to make treatment decisions (ORS 109.675)

SIGNATURE: _____ **DATE:** _____

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PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that **Salem Psychiatric Associates and Valley Mental Health P.C.,** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, 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 This Practice may use and disclose my health information 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 for paying for some of all my healthcare.
- Perform various office, administrative, and business functions that support my provider's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective healthcare.

I also understand that I have a right to receive and review a written description of how This Practice 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 personnel of This Practice, and my rights regarding my health information.

I understand that this 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 or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception areas.

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

By signing below, I confirm that I have reviewed and understand the information above, and that I may request a copy of the Notice of Privacy Practices at any time.

To be signed by client (if 14 years or older and able to consent to treatment) *:

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CLIENT: _____

***Individuals 14 years or older must provide written consent to treatment unless a court or other law authorizes someone other than the individual and/or parent to make treatment decisions (ORS 109.675).**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the administrative office at:

Salem Psychiatric Associates and Valley Mental Health
821 Saginaw St. S
Salem, OR 97302
Phone (503) 589-4046

WHO WILL FOLLOW THIS NOTICE?

This notice describes the privacy practices followed by us, and the office personnel who manage our practice at the above address.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the counseling and care services you have received through Salem Psychiatric Associates and Valley Mental Health. Your health information may include information created and received by your therapist, it may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, counseling, evaluations, test results, prescriptions, diagnoses, treatments, procedures, and related billing activity and/or similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE AND OUR OFFICE PERSONNEL MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

For treatment, with your written consent we may release information to your primary care physician and /or other treating physicians, therapists, counselors, care givers, office staff or other personnel who are involved in taking care of you and your health.

> For example, your doctor may be treating you for a health condition and may need to know if you have issues or problems that could complicate your treatment. The doctor may use this information to decide what treatment is best for you. We may need to confer with your doctor or another clinician in the field of our practice to assist us in a choice of treatment that would be best for you.
>
> Different personnel may share information about you and disclose information to people who do not work in your therapist's office to coordinate your care, such as scheduling appointments and tests. Family members and other health care providers may be part of your medical care and may require information about you that we have.

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For payment: We may use and disclose health information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

For Health Care Operations: We may use and disclose health information about you to make sure that you and our other clients receive quality care. For example, we may use your health information to evaluate the performance of the office personnel who are caring for you. We may also use health information about all or many of our clients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

> We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for helping these plans and providers provide or improve care, reduce cost, coordinate, and manage health care and services, train staff and comply with the law.

Appointment Reminders: Office personnel may contact you by phone as a reminder that you have an appointment for counseling. *Please specify to office personnel what phone numbers they may use to remind you of appointments. Please notify us if you do not wish to be contacted for appointment reminders.*

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks. We may disclose health information about you for public health reasons to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

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Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement along with your written authorization to do so. We will give you an opportunity to object to such a disclosure and request you state this in writing. We may also disclose information to your family or friends if we can infer from circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to limited disclosure of information to your spouse when you bring your spouse with you to a counseling session and have not requested in writing that any form of disclosures cannot be made.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

We will need specific, written authorization from you to disclose certain types of specially protected information such as HIV, substance abuse, mental health, and genetic testing information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to your therapist or our administrative office to set up an appointment to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The

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person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment if your therapists keep the information.

To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to your therapist or Salem Psychiatric Associates and Valley Mental Health, 821 Saginaw Street South, Salem, Or 97302.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- That your therapists did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions, and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

To obtain this list, you must submit your request **in writing** to your therapist or Salem Psychiatric Associates and Valley Mental Health, 821 Saginaw Street South, Salem, Or 97302.

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we do not use or disclose information about a hospitalization you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or we are required by law to use or disclose the information.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to your therapist or to our administrative office at Salem Psychiatric Associates and Valley Mental Health, 821 Saginaw St. S, Salem, OR 97302.

Right to Request Confidential Communications. You have the right to request that we communicate with you about matters in a certain way or at a certain location. For example, you can ask that we only contact you at work by phone or by mail.

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To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL

COMMUNICATION to your therapist or office personnel of Salem Psychiatric Associates and Valley Mental Health. We will not ask you for the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask your therapist or our office personnel to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective from information we already have about you as well as any information we receive in the future. We will post the current notice in the offices of Salem Psychiatric Associates and Valley Mental Health clinicians with the effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with our administrative office, please contact our Complaints Representative at:

COMPLAINT/GRIEVANCE PROCESS

If you feel our service can be improved or feel that your rights as a client have been disregarded, we urge you to first discuss those concerns with the therapist or staff member. If you do not feel that your concerns are adequately addressed, we encourage you to file a complaint by filling out a Feedback Form. A complaint is a verbal or written expression of dissatisfaction. There will be no retaliation for filing a complaint. We see your feedback as an opportunity to improve our services. If you need this information in an alternative format, please contact our office at 503-589-4046.

1. You may file a complaint verbally or in writing. If you express your complaint verbally, either your therapist or a staff member will explain the complaint process and provide you with a copy of the Feedback Form. If you need help with completing the Feedback Form, please let us know and we will make sure someone will help you.
2. Once SPA/VMH receives the complaint, the program manager will confirm the client's health care coverage to ensure compliance with the correct procedure.
3. The program manager will also review the complaint to ensure that it contains all the information needed to answer the complaint. If more information is needed, we will ask you to provide the information within 10 days or at a time which we agree.
4. We will contact you to resolve the complaint within 5 working days of receiving the Feedback Form. If we need more information or cannot resolve the concern, we will let you know why and when we hope to resolve the situation. An extension cannot be for more than 30 calendar days from the date we receive a complaint.
5. We will provide you with a written answer to the complaint. We will speak to each concern in your complaint.
6. **Expedited Grievances**: In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in these rules are completed, the individual, or guardian of the individual, may request an expedited review. The program administrator must review and respond in writing to the grievance

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within 48 hours of receipt of the grievance. The written response must include information about the appeal process.

7. **Retaliation:** A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages, or benefits, or basing service or a performance review on the action.
8. **Immunity**: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.
9. **Appeals:** Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:
   a. If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the Division as applicable.
   b. If requested, program staff must be available to assist the individual.
   c. The Division must provide a written response within ten working days of receipt of the appeal; and
   d. If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten working days of the date of the written response to the Chief Officer.
10. If Salem Psychiatric Associates and Valley Mental Health cannot resolve your grievance, you may contact Pacific Source at 541-382-5920 (toll free at 1- 800-431-4135) or the Oregon Health Authority Human Services Division at 503-945-5763.

LET US KNOW HOW WE CAN BETTER HELP YOU

Do you have any questions, feedback, concerns, or complaints about your services here?

You can:

- Talk with any staff person
- Fill out a Feedback Form (next page) or on our VMH website at www.valleymental.com/forms
- File a Grievance with the Oregon Health Authority at **503-945-5763**

You can also contact your health plan directly. If you are covered by Oregon Health Plan, look on your OHP card to see which of these plans is listed:

PacificSource Community Solutions	Phone: 541-382-5920 (1-800-431-4135)
Division of Medical Assistance Programs	Phone: 1-800-273-0557

For legal help, call Disability Rights Oregon

Phone: 503-243-2081 or 1-800-452-1694

Please refer to the attached SPA/VMH Complaint/Grievance Process for guidance about how to file a complaint or grievance. Or call Oregon Health Authority at 503-945-5763.

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FEEDBACK FORM

DATE: _____

Name of Complainant (optional):	**Name of Client (optional)**
Contact phone number/address:	**Name of staff member receiving complaint:**

What happened? When did it happen? Who was involved? Who have you talked to about this?

What would you like to see happen?

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FEEDBACK FORM

Action taken (resolution and who was involved)

Forwarded to Program Manager?	☐ **Yes**	☐ **No**	**Date:** _____
Letter sent to client?	☐ **Yes**	☐ **No**	**Date:** _____
Reviewed by CAC?	☐ **Yes**	☐ **No**	**Date:** _____
Formal Grievance filed?	☐ **Yes**	☐ **No**	**Date:** _____

If yes, with what agency? _____

Additional Notes:

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VOTER REGISTRATION INFORMATION

As a new client of Salem Psychiatric Associates and Valley Mental Health who is 17 years or older in age and a citizen of the United States of America, we would like to assist you in registering to vote.

A voter registration card may be completed in the following ways:

- Contact your local County Elections Office for a paper form
  - **Marion County:** 503-588-5041 or 1-800-655-5388
  - **Polk County:** 503-623-9217
- Complete voter registration online (English and Spanish) at the following link:
  - https://secure.sos.state.or.us/orestar/vr/register.do
- Ask for assistance from your new SPA/VMH provider to complete the registration process.

FREE TRANSPORTATION SERVICES (OHP)

Only for clients who are covered under Oregon Health Plan

ModivCare, or Non-Emergency Medical Transportation (NEMT) is a **free** ride service that helps you get to and from OHP covered appointments and services.

ModivCare's call center is open Monday through Friday from 6:00am – 7:00pm.

The phone number to call and reserve a ride is: 1-844-544-1397

How to get the most out of the free ride service:

- You MUST call 2 business days before your visit **unless it is an emergency.**
- Plan some extra time on the phone when you call to set up your first ride. Staff will ask you some questions about your needs. This is to make sure you get the right type of ride.

Do you prefer to ride the bus? Call ModivCare ask for a bus pass to help you get to and from your OHP covered appointments and services!

Do you have your own transportation? You can use the mileage reimbursement benefit! This is for travel to and from your OHP covered appointments and services. Request a form from your provider at your first appointment.

If you have any questions or concerns about this letter, please call PacificSource (CCO) Toll Free at 1-800-431-4135 or 541-382-5920. TTY users call 1-800-735-2900.

Si used necesita ayuda en entender esta informacion, por favor llame a linea gratis 1-800-431-4135 or 541-382-5920. Equipo teletranscriptor 1-800-735-2900 para la ayuda.

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OREGON ADVANCED HEALTHCARE DIRECTIVE

An advanced directive will help you describe who you want to make medical decisions on your behalf if you become unable to do so. It will also help you decide what kind of medical treatments you are willing to have if you cannot communicate about treatment options.

Please ask your healthcare provider for assistance if you have questions regarding this form.

A copy of an Oregon Advanced Healthcare Directive is available at
https://www.oregon.gov/oha/ph/about/pages/adac-forms.aspx

You may also ask the front desk, your therapist or your prescriber for a copy of the form.

OREGON DECLARATION OF MENTAL HEALTH

The Oregon Declaration for Mental Health Treatment is a legal document, also known as a Psychiatric Advance Directive (PAD), that lets you specify your wishes for mental health care (like medications, short-term hospitalization, or electroconvulsive therapy) and name a trusted person (a representative) to make decisions for you if you become unable to do so during a mental health crisis, remaining valid for three years or until you regain capacity. Please ask your healthcare provider for assistance if you have questions regarding this form.

Please ask your therapist or medication prescriber for assistance if you have questions regarding this form.

A copy of an Oregon Declaration of Mental Health is available at
https://apps.state.or.us/Forms/Served/le9550.pdf

You may also ask the front desk, your therapist or your prescriber for a copy of the form.