Portland DBT INSTITUTE

Portland DBT Institute Informed Consent Attachments -
Client Rights Notices

****NOTE: The following notices are informational/for your reference only. You do NOT need to fill them out prior to session, but please review the contents in case questions arise. ****

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5200 SW Macadam Avenue
Suite 580
Portland, OR 97239

O 503-231-7854
F 503-231-8153
www.pdbti.org

PORTLAND DBT INSTITUTE, INC.
Notice of Privacy Practices for Protected Health Information
Effective Date: March 2012

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!

The office is permitted by federal privacy laws to make uses and disclosures of your protected health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of the use of your protected health information for the purpose of treatment:

- A clinician obtains treatment information about you and records it in your health record.

Example of use of your protected health information for payment purposes:
We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding health care given. We will provide information to them about you and the care given.

Example of use of your protected health information for health care operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your protected health information by delivering the request to our office -- we are not required to grant the request, but we will comply with any request granted;

- Request a restriction on disclosures of your protected health information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the protected health information pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;

- Obtain a paper copy of the current "Notice of Privacy Practices for Protected Health Information" by making a request at our office;

- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office (there are some exceptions to what you can view such as psychotherapy notes and pieces of information that may be considered harmful to you or others);

- Appeal a denial of access to your protected health information, except in certain circumstances;

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the health information kept by or for the office;

- Is not part of the information that you would be permitted to inspect and copy; or,
- Is accurate and complete.

- If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your protected health information be made by alternative means or at an alternative location by delivering the request in writing to our office;

- Obtain an accounting of disclosures of your protected health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent that action has already been taken.

If you want to exercise any of the above rights, please contact Brianna Johnson, HIPAA Compliance Officer by writing to bjohnson@pdbti.org or 5200 SW Macadam Ave, Ste 580, Portland, OR 97239, or in person during regular business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your protected health information as required by law;

- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;

- Abide by the terms of our Notice;

- Notify you if we cannot accommodate a requested restriction or request; and,

- Accommodate your reasonable requests regarding methods to communicate protected health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of our Notice by calling and requesting a copy of our Notice or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Brianna Johnson, HIPAA Compliance Officer, at bjohnson@pdbti.org. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Reception. You may also file a complaint by filling out the OCR Privacy Compliant Form Package found at www.orosha.org and turning it in via email to OCRMail@hhs.gov, faxing it to (206) 615-2297 or by mailing it to the regional office at 2201 Sixth Ave. M/S: RX-11 Seattle, WA 98121-1831.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office. We also cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, protected health information relevant to that person's involvement in your care or in payment for such care if you do not object or are in an emergency.

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief
We may use and disclose your protected health information to assist in disaster relief efforts.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing injury, or disability; to report reactions to medications; to notify people of recalls.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers
We may release protected health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of others.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat
To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses
Other uses and disclosures, besides those identified in our Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in our Notice under "Your Health Information Rights."

Website
If we maintain a website that provides information about our entity, our Notice will be on the website.

PORTLAND DBT INSTITUTE, INC
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OR 97239
PHONE: (503) 231-7854 FAX: (503) 231-8153

SUMMARY OF SERVICE DELIVERY POLICIES AND PROCEDURES

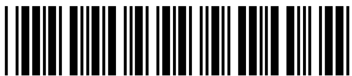
It is important to all of us at the Portland DBT Institute that you are as informed as possible regarding the services we offer and the policies and procedures that govern how they are delivered. We provide mental health assessment and treatment planning, individual therapy, family therapy, group therapy, nutrition therapy, medication management and consultation services to adults, young adults, teens and families.

We take pride in offering research supported treatments and following "evidence-based, best practice guidelines". We believe treatment is a collaborative process that involves providers, clients and their loved ones. Although DBT is generally a protocol driven therapy, we strive to provide an individualized, culturally sensitive treatment experience.

The following provides a summary of Portland DBT Institute's service delivery policy and procedure areas. To obtain more detailed information on any area's policies and procedures, please feel free to ask a Portland DBT Institute staff person.

A) MHADM-060 Client Fees
B) MHADM-110 Confidentiality
C) Compliance with Title 2 ADA Act
D) MHADM-1011 Consumer Complaint/Grievance Process
E) MHADM-120 Consumer Appeals
F) MHADM-061 Client Rights and Responsibilities
G) Quality Management Committee and Quality Improvement Plan
H) Response to Mental Health Emergencies
I) MHADM- 370 Incident Reporting

Oregon Voter Registration Card



SEL 500 rev 11/19

you may use this form to

→ register to vote
→ update your information

1. **Print with a black or blue pen to complete the form.**
2. **Sign the form.**
3. **Mail or drop off the form at your County Elections Office.**

Your County Elections Office will mail you a Voter Notification Card to confirm your registration.

oregonvotes.gov

1 866 673 8683
se habla español

TTY **1 800 735 2900**
for the hearing impaired

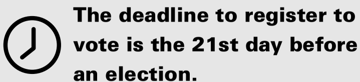
information disclosure

Information submitted on an Oregon Voter Registration Card is public record. However, information submitted in the Oregon Driver's License section is, by law, held confidential.

assistance

If you need assistance registering to vote or voting please contact your County Elections Official. See reverse for contact info.

If you are not yet 18 years of age, you will not receive a ballot until an election occurs on or after your 18th birthday.



The deadline to register to vote is the 21st day before an election.

Only registered voters are eligible to sign petitions.

You must provide your valid Oregon Driver's License, Permit or ID number. A suspended Driver's License is valid, a revoked Driver's License is not valid.

-or-

If you do not have valid Oregon ID, provide the last four digits of your Social Security number.

-or-

If you do not have valid Oregon ID or Social Security number, provide a copy of one of the following that shows your name and current address.

acceptable identification

→ valid photo identification
→ a paycheck stub
→ a utility bill
→ a bank statement
→ a government document
→ proof of eligibility under the Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) or the Voting Accessibility for the Elderly and Handicapped Act (VAEH).

qualifications

Are you a citizen of the United States of America? ☐ yes ☐ no

Are you at least 16 years of age? ☐ yes ☐ no

! ***If you mark no in response to either of these questions, do not complete this form.***

personal information **required information*

last name* ___ first* ___ middle ___

Oregon residence address, city and zip code (include apt. or space number)*

date of birth (month/day/year)* ___ county of residence ___

phone ___ email ___

mailing address, including city, state and zip code (required if different than residence)

Oregon Driver's License/ID number

Provide a valid **Oregon Driver's License, Permit or ID**:

☐☐☐☐☐☐☐

☐ *I do not have a valid **Oregon Driver's License/Permit/ID**. The last 4 digits of my Social Security Number (SSN) are:*

x x x - x x - ☐☐☐☐

☐ *I do not have a valid Oregon Driver's License/Permit/ID or a SSN. I have attached a copy of **acceptable identification**.*

political party

☐ Not a member of a party

☐ Constitution
☐ Democratic
☐ Independent
☐ Libertarian
☐ Pacific Green
☐ Progressive
☐ Republican
☐ Working Families
☐ Other ___

signature *I swear or affirm that I am qualified to be an elector and I have told the truth on this registration.*

sign here ___ date today ___

! ***If you sign this card and know it to be false, you can be fined up to $125,000 and/or imprisoned for up to 5 years.***

registration updates *Complete this section if you are updating your information.*

previous registration name ___ previous county and state ___

home address on previous registration ___ date of birth (month/day/year) ___

Secretary of State
Salem OR 97310-0722

County Elections Offices

Baker County
1995 3rd St, Ste 150
Baker City OR 97814-3365
541 523 8207

Benton County
120 NW 4th St, Rm 13
Corvallis OR 97330-4734
541 766 6756

Clackamas County
1710 Red Soils Ct, Ste 100
Oregon City OR 97045-4300
503 655 8510

Clatsop County
820 Exchange St, Ste 220
Astoria OR 97103-4609
503 325 8511

Columbia County
230 Strand St
St. Helens OR 97051-2040
503 397 7214 or 503 397 3796

Coos County
250 N Baxter St
Coquille OR 97423-1875
541 396 7610

Crook County
300 NE 3rd St, Rm 23
Prineville OR 97754-1919
541 447 6553

Curry County
94235 Moore St, Ste 212
Gold Beach OR 97444-9705
541 247 3297 or 877 739 4218

Deschutes County
1300 NW Wall St, Ste 202
Bend OR 97703-1960

PO Box 6005
Bend OR 97708-6005
541 388 6547

Douglas County
PO Box 10
Roseburg OR 97470-0004
541 440 4252

Gilliam County
PO Box 427
Condon OR 97823-0427
541 384 2311

Grant County
201 S Humbolt, Ste 290
Canyon City OR 97820-6186
541 575 1675

Harney County
450 N Buena Vista, Ste 14
Burns OR 97720-1565
541 573 6641

Hood River County
601 State St
Hood River OR 97031-1871
541 386 1442

Jackson County
1101 W Main St, Ste 201
Medford OR 97501-2369
541 774 6148

Jefferson County
66 SE "D" St, Ste C
Madras OR 97741-1739
541 475 4451

Josephine County
PO Box 69
Grants Pass OR 97528-0203
541 474 5243

Klamath County
305 Main St
Klamath Falls OR 97601-6332
541 883 5134

Lake County
513 Center St
Lakeview OR 97630-1539
541 947 6006

Lane County
275 W 10th Ave
Eugene OR 97401-3008
541 682 4234

Lincoln County
225 W Olive St, Ste 201
Newport OR 97365-3811
541 265 4131

Linn County
300 SW 4th Ave, Rm 205
Albany OR 97321-2393
541 967 3831

Malheur County
251 “B” St W, Ste 4
Vale OR 97918-1375
541 473 5151

Marion County
555 Court St Ne, Ste 2130
Salem OR 97301-3980

PO Box 14500
Salem OR 97309-5036
503 588 5041 or 800 655 5388

Morrow County
PO Box 338
Heppner OR 97836-0338
541 676 5604

Multnomah County
1040 SE Morrison St
Portland OR 97214-2417
503 988 3720

Polk County
850 Main St, Rm 201
Dallas OR 97338-3179
503 623 9217

Sherman County
PO Box 243
Moro OR 97039-0243
541 565 3606

Tillamook County
201 Laurel Ave
Tillamook OR 97141-2311
503 842 3402

Umatilla County
216 SE 4th St, Ste 18
Pendleton OR 97801-2699
541 278 6254

Union County
1001 4th St, Ste D
La Grande OR 97850-2100
541 963 1006

Wallowa County
101 S River St, Ste 100
Enterprise OR 97828-1363
541 426 4543

Wasco County
511 Washington St, Rm 201
The Dalles OR 97058-2237
541 506 2530

Washington County
2925 NE Aloclek Dr, Ste 170
Hillsboro OR 97124-7523
503 846 5800

Wheeler County
PO Box 327
Fossil OR 97830-0327
541 763 2400

Yamhill County
414 NE Evans St
McMinnville OR 97128-4607
503 434 7518

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CLIENT'S RIGHTS AND RESPONSIBILITIES

Clients receiving treatment at the Portland DBT Institute have the right to:

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

(a) Choose from services and supports that are consistent with the assessment and service plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for the greatest degree of independence;
(b) Be treated with dignity and respect;
(c) Participate in the development of a written service plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written service plan;
(d) Have all services explained, including expected outcomes and possible risks;
(e) Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50;
(f) Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:

(A) Under age 18 and lawfully married;
(B) Age 16 or older and legally emancipated by the court; or
(C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.

(g) Inspect their service record in accordance with ORS 179.505;
(h) Refuse participation in experimentation;
(i) Receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence;
(j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
(k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
(l) Have religious freedom;
(m) Be free from seclusion and restraint;
(n) Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;
(o) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented;
(p) Have family and guardian involvement in service planning and delivery;
(q) Have an opportunity to make a declaration for mental health treatment, when legally an adult;
(r) File grievances, including appealing decisions resulting from the grievance;
(s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
(t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
(u) Exercise all rights described in this rule without any form of reprisal or punishment.

(2) The provider shall give to the individual and, if appropriate, the guardian a document that describes the applicable individual's rights as follows:

(a) Information given to the individual shall be in written form or, upon request, in an alternative format or language appropriate to the individual's need;
(b) The rights and how to exercise them shall be explained to the individual, and if applicable the guardian; and
(c) Individual rights shall be posted in writing in a common area.

In addition, adult clients receiving treatment at the Portland DBT Institute have the responsibility to:

1. Be on time for appointments and call their therapist with 24 hours notice if there is a need to cancel.
2. Provide, to the extent possible, information that their therapist needs in order to provide psychological and other behavioral health services to you.
3. Participate, to the degree possible, in understanding their psychological/behavioral health condition and develop mutually agreed upon treatment goals.
4. Follow the plans and instructions for care that are agreed upon with their therapist.
5. Review their insurance benefit booklet or call their insurance customer relations representative to make sure services are covered under their plan and follow plan requirements to have services properly authorized.
6. Pay all agreed upon out-of-pocket charges and fees, as negotiated with their therapist and outlined in their treatment plan, providing such fees are in compliance with their insurance company contract.

PORTLAND DBT INSTITUTE, INC: COMPLAINT AND GRIEVANCE POLICIES AND PROCEDURES

Complaint and Grievance Policy and Procedure

Clients and their guardians are informed at intake of their right to file a grievance or complaint, and to receive assistance when needed in submitting a grievance or complaint. Complaints and grievances can be submitted in writing or verbally to the Associate Director. Clients may also submit this complaint or grievance to an outside entity, such as a County, at any time. PDBTI clients and guardians will be fully informed of this policy as well as the procedure and process:

- Information will be provided verbally and in writing. If English is not the client or guardian's primary or preferred language, the client will be provided the document in their preferred language or other alternative format.
- Copies of grievance forms and of the grievance and complaint policies and procedures are both available in the waiting room where the clients have easy access to them.
- The Associate Director will investigate the nature of the grievance and seek to reach an acceptable and reasonable resolution of the grievance within 30 (thirty) days. In instances where a person's health is at risk, an expedited process of 48 (forty-eight) hours will be implemented.
- If the client or legal guardian who has submitted the grievance remains dissatisfied with the suggested resolution, he/she may choose to take their grievance outside the program (e.g., to a licensing board, a state professional organization, a client rights advocacy group, the insurance commissioner). Appeals should be directed to Oregon Health Authority, Health Systems Division ("the Division") or CMHP (Community Mental Health Program).
- A Grievance Process Notice is posted in the waiting area of the clinic and lists the telephone number of:
    - (a) The Division;
    - (b) The CMHP;
    - (c) Disability Rights Oregon;
    - (d) The Governor's Advocacy office, and
    - (e) The applicable managed care organization(s).
- The receipt, investigation and action taken regarding the grievance shall be documented in the client's chart and in the Quality Assurance meeting minutes.
- Both formal and informal complaints made by Multnomah County MHASD consumers that are resolved with PDBTI shall be reported to the Quality Management Program in a Complaint Log by the 5th of each month.
- Grievances that have been submitted in writing and response to a written grievance will be reviewed and documented by the management staff monthly.
- A grievant, witness or staff member of PDBTI will not be subject to retaliation by a PDBTI 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.
- The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.
- Individuals and their legal guardians may appeal entry, transfer, and grievance decisions as follows:
    - a) If the individual or guardian is not satisfied with the decision, the individual or guardian may file and appeal in writing within 10 (ten) working days of the date of the Associate Director's response or notification of denial for services. The appeal shall be submitted to the Division;
    - b) If requested, program staff shall be available to assist the individual;
    - c) The Division shall provide a written response within 10 (ten) working days of the receipt of the appeal; and
    - d) If the individual or guardian is not satisfied with the appeal decision, they may file a second appeal in writing within 10 (ten) working days of the date of the written response to the Division Director.

All grievances will be kept confidential unless the law requires that they be disclosed, and if disclosure is so required, the Institute Director will disclose them to as few persons as possible.

PORTLAND DBT INSTITUTE, INC
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COMPLAINT/GRIEVANCE FORM

To be completed by the client, the client's representative, or a Portland DBT Institute staff person. Please ask for assistance if you need help completing this form. Also, see "Complaint & Grievance Policies and Procedures".

Name: ____ Date: ______________ Phone: __________________________________

Address: ____ Email: ____

PDBTI Providers: Individual therapist: _____________________________ Group therapist: _____________________________

Current insurance provider, if applicable: ____
(Insurance information is requested so that Portland DBT Institute can share general information with your insurance company or managed care organization if the complaint is of a financial nature. Personal/unnecessary information will not be disclosed).

Date & place of incident: ____

Complaint Type [please *check* one]:
[ ] Resolved (Problem resolved after discussion with staff) [ ] Unresolved (Problem not resolved after discussion with staff)

Concern or complaint (include names of staff involved):

____

____

____

____

Please use the back of this form and/or attach another sheet of paper if more space is needed.

Have you shared your concerns with staff involved? Yes [ ] No [ ]

Does the nature of your complaint involve risk to health and safety requiring an immediate review (within 48 hours)? Yes [ ] No [ ]
If yes, please explain:

____

____

____

____

How would you like the problem resolved?:

____

____

____

____

Client or Client Representative Signature: ____

Please mail the competed form to: Portland DBT Institute, Inc. ATTN: Associate Director, 5200 SW Macadam Ave, Suite 580, Portland, OR 97239. You may also hand deliver the form to a staff person at Portland DBT Institute.

For Internal Use Only:
Received from client by (staff member name): _______________________________________ Date/time received: _______________
RECEIVING STAFF: Upon receipt of this form, please provide client with a copy.

Sent to for review/response (staff member name): ____ Date sent: __________________
RESPONDING STAFF: Director, Associate Director, Program Manager, Business Operations Manager (QA Committee should receive a **copy** for review/file).

Can I plan now for the mental health treatment I would want if I were in crisis?

If you have a disability and need this document in an alternate format, please call 503-945-9716 (voice) or 800-375-2863 (TTY)

A Guide to Oregon's Declaration for Mental Health Treatment

Revised April 2015

ANSWERS TO QUESTIONS

Planning for Your Mental Health Treatment

Can I plan now for the mental health treatment I would want if I were in crisis?

Yes. You can plan now for a time when you may be unable to make your own mental health treatment decisions.

How can I plan ahead?

Oregon has a form that you can fill out and sign now to protect yourself when you may be in crisis and are unable to make your own treatment decisions. This form is called a **Declaration for Mental Health Treatment**.

Who decides if I am unable to make my own treatment decisions?

Only a court or two physicians can decide if you are unable to understand and make decisions about your mental health treatment.

*A **Declaration** form is used only when you are unable to understand and make decisions about your mental health treatment.*

What kind of advance planning does Oregon's Declaration for Mental Health Treatment allow me to make?

You can make choices about your future mental health care. You can describe the kind of care that you want to receive. You can also describe the kind of care you do not want to receive.

You can also provide additional information about your mental health treatment needs.

*It is wise to prepare this part of the **Declaration** carefully. You may want to discuss this section with your physician or mental health provider.*

Can I ask someone to speak for me when I am in crisis and can't speak for myself?

Yes. You can choose an adult to represent you. This should be someone *you trust* who can make decisions about your mental health care when you cannot do so for yourself. Of course, the person you name must agree to do so.

On the **Declaration** form the person you choose is called a *Representative.*

Do I have to choose a lawyer?

No.

Can my representative make mental health treatment decisions that change my own wishes for treatment?

No. Your representative ***must*** follow your wishes. It is wise to talk to your representative about your wishes.

Even if you have not made your wishes known, your representative must make decisions for that are as close as possible to the kind of decision you would make yourself if you were capable of doing so.

Your physician is not required to give you the medicine you have chosen in your **Declaration** form if your physician believes that it is not good for you. However, your physician must have your representative's *permission* to give you a medicine that is *not listed* in the **Declaration**.

This is why it is important for you to choose someone who knows you well and whom you trust.

How can I make sure that my instructions will be followed?

In order for your instructions to be followed, you or your representative *must* give copies of your completed **Declaration** form to your physician or mental health provider. Your representative should keep a copy, and it is wise to keep a copy for yourself.

Can my instructions ever be changed?

Whether or not you have signed a **Declaration** form, if you are on an emergency psychiatric hold, or if you have been committed by a court, your physician may still give you medicine that you didn't want. Your physician can only do this under very strict legal guidelines.

If I make out and sign a Declaration for Mental Health Treatment will it be good forever?

No. A signed **Declaration for Mental Health Treatment** only will be valid for 3 years and must be renewed. However, should you become incapable of making mental health treatment decisions during these 3 years the **Declaration** will remain until the time-whenever that may be-that you regain capacity to make your own decisions.

Can I change my written instructions for mental health treatment or cancel my Declaration form?

Yes. As long as you are able to understand the information given to you about the choices that you may make for your mental health treatment, you may change your written mental health treatment instructions or cancel your **Declaration** form.

Of course, in order to make sure that your wishes are followed, you ***must*** give your physician or mental health provider a new **Declaration** form that includes the changes you wish.

However, if a court or two physicians decide that you are *unable to understand your mental health treatment options and you are not capable of making choices about your mental health treatment*, you will not be permitted to change your written instructions or to cancel your **Declaration** until the time that you regain capacity to understand your treatment options.

But, this is why you have written out your future wishes on this **Declaration for Mental Health Treatment** form: *You want to protect yourself when you are in crisis and are unable to make your own treatment decisions.*

If I move out of the state of Oregon, will my Declaration form be valid?

It depends on where you go. Each state has its own rules.

Can anyone force me to make out a Declaration for Mental Health ?

No. *No one,* no insurer, no physician, no mental health treatment provider, nor any other person is permitted to attempt to force you to make out a **Declaration** form. It should be your *free choice* to make out and sign the **Declaration for Mental Health Treatment**.

Witnesses who sign your **Declaration** form should be people whom you know and trust. They can verify that you signed the form by your own free choice, *without being forced.*

INSTRUCTIONS

It is entirely your choice as to whether or not you want to have a Declaration For Mental Health Treatment **(Declaration)**.

Before you fill out your **Declaration**, you should carefully read the

"NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT"
as well as the
"NOTICE TO PHYSICIAN OR PROVIDER"

which are found on pages 8 through 9 of the **Declaration** form. These notices give you some general information about the **Declaration**.

Once you make your **Declaration**, it stays in effect for three years unless you revoke it. After three years, it is not valid. You need to sign a new declaration. If you are incapable at the end of three years to sign a new **Declaration**, the **Declaration** stays in effect until you are capable again.

If you decide that you do not want to have a **Declaration** or you want to change it, you can. To revoke the **Declaration**, you tell your doctor, your provider and anyone else who has your **Declaration** that you do not want it to be in effect. To be safe, you should do this in writing or get all the copies of the **Declaration** and tear them up. Also, you cannot revoke your **Declaration** during a time when you have been found incapable.

If there is anything in this document that you do not understand after reading the notices and the following instructions, then you should ask an attorney to explain it to you.

How To Fill Out A Declaration For Mental Health Treatment Form

First Things First

First, you must be mentally competent to make a **Declaration**. Second, you need an official form to fill out. You cannot make a legal **Declaration** without one, The form attached to these instructions is official and will be valid if it is correctly filled out, signed and witnessed.

To be valid and effective the form must:

a. Contain your name.

b. Be signed and dated by you.

c. Be signed and dated by two witnesses who were present when you signed the **Declaration**. *They must believe you are mentally competent at the time you sign the form.*

d. Contain your instructions about mental health treatment.

Follow these steps to make a legally valid ***Declaration for Mental Health Treatment***:

Step 1 - Name

Print or type your name legibly on the first line of the form after the word "I".

Step 2 - Choice of Decision Maker

In the next section, you must choose who will make decisions for you if you become incapable of giving consent for mental health treatment. You can choose either the person who will be treating you or a "Representative". Place your initials on the line next to your *one* choice.

Although the form does not say so, some people cannot act as your "Representative". People who CANNOT be your "Representative" are:

- Your doctor, mental health service provider, or an employee of your doctor or provider, unless you are related to that person.

- An owner, operator, or employee of a health care facility where you live or are a patient, unless you are related to that person.

If you do not appoint a "Representative" or if the person you appoint does not accept appointment or is disqualified from serving, all of the other instructions in the **Declaration** are still valid.

Step 3 - Appointed Representative

If you choose a "Representative", then fill in each blank with the information requested about that person on page 3 of the form. If you choose to designate someone to be the alternate to your "Representative", then complete the information regarding the alternate "Representative" also on page 3 of the form.

Step 4 - Directions For Mental Health Treatment

The next part of the form, which is entitled "DIRECTIONS FOR MENTAL HEALTH TREATMENT" is where you put your instructions about the mental health treatment you want and don't want. Your directions may include your wishes regarding medications, admission and staying at a mental health treatment facility (for no longer than 17 days), convulsive treatment as well as outpatient services. This section is divided into 3 separate parts, which are addressed in this instructions section as Step 4A, Step 4B, and Step 4C.

Step 4A - Mental Health Treatments That You Consent To

On page 4 of the form, under the "DIRECTIONS FOR MENTAL HEALTH TREATMENT" is where you put instructions about what types of mental health

treatment you want to approve. If you want specific instructions to be followed by a provider or your "Representative", those instructions must be put here.

- If you want to give consent for certain types of drugs, then you should specify which particular medications you approve.

- If you want to give consent to any drug the doctor may recommend, state "I give consent for any medication that my doctor recommends for me."

- If you want to limit your consent in any way, such as to maximum dosage, or you want certain information considered such as allergies you may have, you may add these instructions or information. You may specify your conditions or limitations. You may also state why a specific medication in a specified dosage should be used.

- If you have a "Representative", it will be assumed that your "Representative" must consent to the dosage and type of medication.

- If you agree to short-term inpatient treatment, you may so specify. You may also specify the particular facility and/ or provider you consent to for this short-term inpatient treatment.

- You may agree to convulsive treatment, which includes "shock treatment" or "ECT"(Electroconvulsive treatment). If you want to make a decision in advance about this sort of treatment, you may do so in this section or in Step 4B. You may include a limitation on the number or type of treatments you consent to or a direction to consult your "Representative" for these decisions.

- If you state that you consent to any sort of mental health treatment, you will not necessarily receive it. A doctor must first recommend the treatment for your condition. Your consent does not give a doctor the right to make improper recommendations.

Step 4B - Mental Health Treatments That You Do Not Consent To

The next set of spaces for you to fill in on the form, at the top of page 5, is where you put instructions about what types of mental health treatment you do not

consent to. If you want specific instructions to be followed by a provider or your "Representative", then those instructions must be put here. You should be aware that you may be treated without consent if you are held pursuant to civil commitment law or are in an emergency situation where your life or health is endangered.

- If you do not want to give consent for certain types of drugs or dosage, state that "I do not consent to the administration of the following medications: _______________" and write down the names or types of drugs you are refusing.

- If you want to refuse to consent to taking all drugs, write: "I refuse to consent to taking all medications".

- If you want to explain your refusal of consent, this can be specified. For example, you may corroborate your refusal by documenting the adverse effects, allergies or mis-diagnosis you have experienced from a particular medication and/ or mental health treatment.

- If you do not agree to short-term inpatient treatment, you may so specify. You may also specify that you do not agree to a particular facility and/or to a particular provider for this short-term inpatient treatment.

- If you do not agree to convulsive treatment and want to make a decision in advance about this sort of treatment, which includes "shock treatment" or "ECT" (Electroconvulsive treatment), you may so state.

Step 4C - Additional Information About Your Mental Health

At the top of page 6 is where you put additional information about your mental health needs. You may include anything relevant to your wishes regarding your mental health treatment in this section. The form asks you to consider mental health history; physical health history; dietary requirements; religious concerns; people to notify; and other matters of importance. "Other matters of importance" could be anything related to the treatment that you feel may improve your mental health.

- For example, you can say, that when you are really upset, what calms you down the most is to sit quietly in a dark room, with the door left open. On the other hand, you can specify that the worst thing for you when you are really upset is to be placed in a locked room. The doctor does not have to follow these instructions, but if the doctor is aware of what works and what does not work, s/he may be willing to treat you according to your wishes.

- If you recognize through your experience that regular participation in a consumer run drop-in center provides you with the greatest sense of relief, then you can request that your therapy include participation in a consumer run drop-in center. Your choice does not guarantee that any such program will be available.

- If you would like to ensure that somebody is or is not told that you are in crisis/ in the hospital, then you may so specify.

Step 5 - Your Signature

Sign and date the form at the bottom of page 6. Do this in front of two witnesses. Your signature must appear in this place for any part of the directive to be effective.

Step 6 - Affirmation of Witnesses

Have your two witnesses sign and date the form on page 7 in the section headed "***Affirmation of Witnesses***".

Some people CANNOT act as witnesses. People who CANNOT act as your witnesses include:

- Your "Representative" or alternate "Representative". Anyone you appoint in Step 2 ("Choice of Decision Maker") cannot be a witness.

- A physician or mental health service provider who is treating you, or a relative of a person who is treating you. Your case manager, any doctor who is treating you while you are in the hospital, your counselor or private psychiatrist cannot serve as witnesses.

- The owner or operator of the facility where you live, or a relative of one of these people. For example, if you live in a group home, the owner or staff of the group home cannot serve as witnesses. The same is true of staff at nursing homes, foster homes, board and care homes, etc.

- A person related to you by blood, marriage or adoption.

<u>When the witnesses sign the form they acknowledge that</u>:

(1) you signed the **Declaration**;

(2) *they believe you were mentally competent at the time you signed the form; and*

(3) they believe that you were not under duress, fraud or undue influence at the time you signed the form.

Step 7 - Others' Signatures

If you have a "Representative", then make sure that your "Representative" has signed and dated the acceptance of appointment on page 7. Likewise if you have an alternate "Representative", make sure that your alternate "Representative" has signed and dated the acceptance of appointment on page 7.

Step 8 - Hand Out Copies

Make sure that you give copies of the completed form to any doctor, provider, or facility from which you expect to need treatment. If you have appointed a representative, make sure that this person also has a copy. Your instructions cannot be followed if they are not known to exist.

Declaration for Mental Health Treatment

Attention: This is a legal document which contains important information regarding the affected person's preferences or instructions for mental health treatment.

Declaration for Mental Health Treatment

I, ____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment. I want this declaration to be followed if a court or two physicians determine that I am unable to make decisions for myself because my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means treatment of mental illness with psychoactive medication, admission to and retention in a health care facility for a period up to 17 days, convulsive treatment and outpatient services that are specified in this declaration.

Choice of Decision Maker

If I become incapable of giving or withholding informed consent for mental health treatment, I want these decisions to made by: (INITIAL ONLY ONE)

____ My appointed representative consistent with my desires, or, if my desires are unknown by my representative, in what my representative believes to be my best interests.

____ By the mental health treatment provider who requires my consent in order to treat me, but only as specifically authorized in this declaration.

Appointed Representative

If I have chosen to appoint a representative to make mental health treatment decisions for me when I am incapable, I an naming that person here. I may also name an alternate representative to serve. Each person I appoint must accept my appointment in order to serve. I understand that I am not required to appoint a representative in order to complete this declaration.

I hereby appoint: NAME____________________________________

ADDRESS_________________________________

____

TELEPHONE #_____________________________

to act as my representative to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

(OPTIONAL)

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my representative, I authorize the following person to act as my representative:

NAME____________________________________

ADDRESS_________________________________

____

TELEPHONE #_____________________________

My representative is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my representative. If my desires are not expressed and are not otherwise known by my representative, my representative is to act in what he or she believes to be my best interests. My representative is also authorized to receive information regarding proposed mental health treatment and to receive, review and consent to disclosure of medical records relating to that treatment.

Directions for Mental Health Treatment

This declaration permits me to state my wishes regarding mental health treatments including psychoactive medications, admission to and retention in a health are facility for mental health treatment for a period not to exceed 17 days, convulsive treatment and outpatient services.

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes are: **I CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENTS**: (May include types and dosage of medications, short-term inpatient treatment, a preferred provider or facility, transport to a provider or facility, convulsive treatment or alternative outpatient treatments.)

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I DO NOT CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENT: (Consider including your reasons, such as past adverse reaction, allergies or misdiagnosis. Be aware that a person may be treated without consent if the person is held pursuant to civil commitment law.)

ADDITIONAL INFORMATION ABOUT MY MENTAL HEALTH TREATMENT NEEDS: (Consider including mental or physical health history, dietary requirements, religious concerns, people to notify and other matters of importance.)

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YOU MUST SIGN AND DATE HERE FOR THIS DECLARATION TO BE EFFECTIVE:

Signature and Date:____

Affirmation of Witnesses

I affirm that the person signing this declaration:
(a) Is personally known to me;
(b) Signed or acknowledged his or her signature on this declaration in my presence;
(c) Appears to be sound mind and not under duress, fraud or undue influence;
(d) Is not related to me by blood, marriage or adoption;
(e) Is not a patient or resident in a facility that I or my relative owns or operates;
(f) Is not my patient and does not receive mental health services from me or my relative; and
(g) Has not appointed me as a representative in this document.

Witnessed by:

____

[Signature of Witness (Printed Name of Witness)/Date]

____

[Signature of Witness (Printed Name of Witness)/Date]

Acceptance of Appointment As Representative

I accept this appointment and agree to serve as representative to make mental health treatment decisions. I understand that I must act consistently with the desires of the person I represent, as expressed in this declaration or, if not expressed, as otherwise known by me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document gives me authority to make decisions about mental health treatment only while that person has been determined to be incapable of making those decisions by a court or two physicians. I understand that the person who appointed me may revoke this declaration in whole or in part by communicating the revocation to the attending physician or other provider when the person is not incapable.

____

[Signature of Representative (Printed name) and Date]

____

[Signature of Alternate Representative (Printed name) and Date]

Notice to Person Making A Declaration for Mental Health Treatment

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about certain types of mental health treatment: psychoactive medication, short-term (not to exceed 17 days) admission to a treatment facility, convulsive treatment and outpatient services. Outpatient services are mental health services provided by appointment by licensed professionals and programs. The instructions that you include in this declaration will be followed only if a court or two physicians believe that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held pursuant to civil commitment law.

You may also appoint a person as your representative to make treatment decisions for you if you become incapable. The person you appoint has a duty to act consistently with your desires as stated in this document or, if not stated, as otherwise known by the representative. If your representative does not know your desires, he or she must make decisions in your best interests. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your representative at any time. A "representative" is also referred to as an "attorney-in-fact" in state law but this person does not need to be an attorney at law.

This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable. ***YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT OR TWO PHYSICIANS.*** A revocation is effective when it is communicated to your attending physician or other provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Notice to Physician or Provider

Under Oregon law, a person may use this declaration to provide consent for mental health treatment or to appoint a representative to make mental health treatment decisions when the person is incapable of making those decisions. A person is "incapable" when, in the opinion of a court or two physicians, the person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions. This document becomes operative when it is delivered to the person's physician or other provider and remains valid until revoked or expired. Upon being presented with this declaration, a physician or provider must make it a part of the person's medical record. When acting under authority of the declaration, a physician or provider must comply with it to the fullest extent possible. If the physician or provider is unwilling to comply with the declaration, the physician or provider may withdraw from providing treatment consistent with professional judgment and must promptly notify the person and the person's representative and document the notification in the person's medical record. A physician or provider who administers or does not administer mental health treatment according to and in good faith reliance upon the validity of this declaration is not subject to criminal prosecution, civil liability or professional disciplinary action resulting from a subsequent finding of the declaration's invalidity.

This Guide to Oregon's Declaration for Mental Health Treatment and Form was developed pursuant to Oregon Revised Statutes (ORS) 127.700 through 127.736.

For additional information contact:

Oregon Health Authority
Addictions and Mental Health Division
500 Summer Street NE, E-86
Salem, Oregon 97301
503- 945-9716

NAMI-Oregon
4701 SE 24th Ave., Suite E
Portland, OR 97202
503-230-8009

Disability Rights Oregon
610 SW Broadway, Suite 200
Portland, OR 97205
503-243-2081

Here is a card you can fill out and carry with you:

Emergency Medical Information

Name: ______________________________

I have written a **Declaration for Mental Health Treatment** which is on file at:

____

Immediately contact my Representative at:

____

Name Phone

or Alternate Representative at:

____

Name Phone

ACKNOWLEDGMENTS

Authored in 1994 by:

Patricia Backlar
Center for Ethics in Health Care
Oregon Health Sciences University

Editorial Board:

Brett D. Asmann, M.A.
Project Coordinator

Mary Alice Brown, Ph.D.

Roderick Calkins, Ph.D.

Nellie Fox-Edwards

Gary Cornelius

Theodore Falk, J.D., Ph.D.

Michael Garland, D.Sc. Rel.

Rex Surface, M.S.W.

Robert C. Joondeph, J.D.
Authored Instructions

Richard C. Lippincott, M.D.

Sandra Millius

Linda O'Mallia, M.C.S.W., B.C.D.

Garrett Smith, M.P.A.

Gary Smith, M.S.

Stanley Sturges, M.D.

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Updated by:

Robert C. Joondeph, J.D., Oregon Advocacy Center
Jan E. Friedman, J.D., Oregon Advocacy Center
Bob Nikkel, Office of Mental Health and Addiction Services
Jamie Rockwell, Office of Mental Health and Addiction Services

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