Phoenix Counseling Center, Inc.

149 S Main Street, PO Box 1257, Phoenix, OR 97535
541-535-4133 541-535-5458 fax

Consent for Treatment

Phoenix Counseling Center utilizes a client-centered, trauma-informed approach. Our motto, "Counseling from the Heart," describes the warm, home-like setting you will experience while in treatment at Phoenix Counseling Center.

We are a nonprofit, outpatient counseling center offering substance use and mental health services for adults, adolescents, parents, and families living in the Rogue Valley. Our treatment services include individual, group, couples, and family counseling sessions for voluntary and mandated clients.

There are potential risks associated with any form of counseling. Risks might include experiencing unpleasant and/or uncomfortable feelings. Counseling also involves the potential benefit for greater awareness of self, improved problem-solving abilities, improved communication skills, and stable recovery.

At Phoenix Counseling Center you can be assured that no information you share with your counselor or other staff member will be shared with anyone outside of agency staff, unless you have given us written consent to do so.

We also expect you to honor the confidentiality of other clients at the agency. Please do not share any information you receive from other clients with anyone else, unless that information concerns threat of harm to that client or to others, in which case the information should only be shared with a staff member who will then inform the appropriate entities. Confidentiality is important in the group setting so that you and others may feel comfortable to share what you want. Breaches of confidentiality regarding information gained from other clients/group members (including names of group members) may result in you being discharged from services at Phoenix Counseling Center.

My signature on this document indicates that I understand there may be possible risks and benefits associated with treatment.

I have chosen to participate in outpatient counseling, either voluntarily or in order to comply with mandates. I understand and agree that I will participate in services and that I may discontinue treatment and/or withdraw my consent for treatment at any time.

Welcome to Phoenix Counseling Center

_____ Your treatment may include a combination of individual and group sessions. You and your counselor will create your individual service plan, according to your specific goals and needs.

_____ Treatment is most successful through consistent attendance. Please attend all weekly treatment sessions.

_____ Check-in at the front office 10-15 minutes before your session.

_____ If you need to miss a scheduled appointment, please notify us 24 hours in advance.

_____ Counseling fees are due at the time of service, unless other arrangements have been made.

_____ Research has shown that clients who provide UAs as part of their drug and alcohol treatment hold themselves more accountable and are more successful. Therefore, you can expect that your counselor will ask you to provide random UAs throughout your treatment experience. If, at any time, you choose not to UA when requested, that UA will be counted as a positive.

_____ Abstinence from all substances is the primary goal of treatment at Phoenix Counseling Center.

_____ Any threats or acts of violence toward staff or other clients, or the possession/use of a weapon will invalidate your right to confidentiality and appropriate action will be taken (including contacting law enforcement).

_____ If you are on any prescription medications, we will ask you for a copy of them for your file.

_____ If a staff member suspects that you are under the influence of a substance while at PCCi:

- You may be asked to provide a UA
- We will work with you to ensure that you get a safe ride home

_____ If you attend group and the facilitator believes that you are under the influence of a substance, you will be asked to leave group.

_____ If you are mandated to treatment and sign a release, information such as: attendance, UA results, progress, and treatment goals will be shared with the mandating agency. We encourage and support clients in holding themselves accountable with their mandating agency.

_____ If you find yourself struggling with treatment goals, you and your counselor may look at other options for increasing your treatment activities and/or level of care.

_____ We encourage you to check out 12-Step or other recovery programs during the course of your treatment.

Welcome to Phoenix Counseling Center, we are glad you chose us as your treatment providers. We care about you, we want you to be successful, and we look forward to working collaboratively with you. We are honored that you chose us to be your partner on this journey.

Revised 4/2020

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Consent for Telehealth

Effective: 3/16/2020
Revised: 5/24/2023

While you are attending services with Phoenix Counseling Center, there may be times when services will be delivered via telehealth (interactive video conferencing) in lieu of or in addition to "in-person" sessions. The video conferencing service that we use is Zoom (www.zoom.com), which meets the HIPAA standards of encryption and privacy protection.

Risks may include, but are not limited to, technology dropping due to internet connections, delays due to connections or other technologies, or a breach of information that is beyond our control. Clinical risks such as discomfort with virtual face to face versus in-person services, difficulties interpreting non-verbal communication, and importantly, limited access to immediate resources if risk of self-harm or risk to others becomes apparent. You should discuss with and any other concerns with your counselor before using telehealth. By signing this document, you are stating that you are aware your counselor may contact necessary authorities in case of an emergency. You are also acknowledging that if you believe there is imminent danger to yourself or others you will seek immediate care through your own health care provider, hospital emergency department, or by calling 911. If you join from a location other than the address we have on file for you, you must inform your clinician of your current location.

If we schedule telehealth sessions with you, all of the agreements you have previously consented to when you enrolled in services are still in effect. This includes, but is not limited to, fees and payments, attendance and cancellation policies. Mandatory reporting laws regarding child, elder, and dependent adult abuse, and any threats of violence will be reported to appropriate authorities. All HIPAA confidentiality laws will be adhered to. Further, I understand that the dissemination of any personally identifiable images or information from the telehealth interaction to any other entities shall not occur without written permission. I will never attempt to capture of disseminate images of other participants (i.e. while attending group sessions).

When participating in sessions via telehealth, I will provide a quiet, interruption-free environment where I Can reasonably assure my own privacy and confidentiality, as well as that of other participants (if attending telehealth groups). I may be asked to prove this by showing the environment to ensure privacy.

I have read and agree to the above terms.

_____ _____

Name DOB

_____ _____

Signature Date

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HIPAA Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that by signing this consent I authorize PCCi to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).

- Obtaining payment from third party payers (e.g. my insurance company).

- The day-to-day healthcare operations of this practice.

I have also been informed of and given the right to review and secure a copy of PCCi's Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that PCCi reserves the right to change the terms of this notice from time to time and that I may contact PCCi at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that PCCi is not required to agree to these requested restrictions. However, if PCCi does agree, PCCi is then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

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Individual Rights

While in Treatment You Have the Right:

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

(a) Choose from available services and supports, those that 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;

(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 to 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) Notification of Rights: The provider must 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 must 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.

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EXCEPTIONS TO CONFIDENTIALITY

Confidentiality and privileged communication are your rights as a client. In general, a written release must be signed before the counselor may disclose any information about you to a third party. However, there are some exceptions to confidentiality, including:

- Information regarding a client's serious intention to harm or kill themselves or others.
- CEO and state representatives conducting business.
- Emergency situations involving events beyond Phoenix Counseling's control (i.e. natural disasters, crime or medical emergencies on the premises, etc.) *45 cfr parts 160, 162, and 164*
- Notes or records subpoenaed by judicial order.
- Any suspicion of abuse of a child, elder or disabled person must be reported. The client will be given the opportunity to make any report necessary; however, the counselor must be present and is *required* to make the report if the client is unable or unwilling to do so.

Revised 10-2017

PHOENIX COUNSELING CENTER, INC.

149 S. Main Street, PO Box 1257, Phoenix, OR 97535
Phone: 541/535-4133 Fax: 541/535-5458

No Smoking Policy

- Phoenix Counseling Center (PCCI) is a non-smoking agency in accordance with Oregon Administrative Rules.
- PCCI prohibits smoking in any of the center's buildings or on any of its grounds.
- Smoking is not permitted within 10 feet of any entrance, exit, window or air-intake vent.
- No smoking signs are posted in visible areas inside and outside the buildings.
- Clients violating this policy will be asked to stop smoking.
- Clients who repeatedly violate this policy may be discharged.
- Clients will be offered an introduction to smoking cessation as part of their treatment plan.
- PCCI offers smoking cessation counseling for clients who wish to stop smoking.

OAR 309-032-1540 "Outpatient programs must not allow tobacco use in program facilities and on program grounds.....Tobacco use is not permitted in any alcohol or other drug treatment program facilities in Oregon".

OAR 433.840 "The people of Oregon find that because exposure to secondhand smoke is known to cause cancer and other chronic diseases such as heart disease, asthma, and bronchitis it is necessary to reduce exposure to tobacco smoke by prohibiting smoking in all public places and place of employment".

- I understand that if I desire to stop smoking while engaged in treatment at PCCI, I will be offered smoking cessation counseling.
- I understand that if I have trouble abstaining from cigarette smoking while attending group at PCCI, I will be offered help and ideas on how to take 'comfortable breaks'.
- I understand that smoking is not permitted on the PCCI campus, it's grounds and near surrounding premises. I will make a concerted effort not to smoke when I am here for individual sessions or groups. If I am having difficulties, I will ask my counselor for help.

Revised 10-2017

Phoenix Counseling Center
149 S. Main Street, Phoenix, OR 97535

Notice of Privacy Practices

Effective 11/25/14

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

If you have any questions about this notice, please contact our office at 541-535-4133 or by mail to:
Phoenix Counseling Center, P.O. Box 1257, Phoenix, OR 97535

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. These records may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

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

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

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 the purpose of 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.

For Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office. This may be done by telephone and/or by mail. If you have an answering machine we may leave a discreet message regarding your appointment.

Required By Law

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

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.

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.

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.

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.

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 as long as the information is kept by this office. 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:

- We 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 health information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

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 health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

- You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
- We reserve the right to change this notice.
- If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.** To file a complaint with our office, contact:

  Phoenix Counseling Center
  149 S. Main St., P.O. Box 1257
  Phoenix, OR 97535
  Phone 541-535-4133

Grievance and Appeals Policy and Procedure

Any individual receiving services, or the parent/guardian of the individual receiving services, may file a grievance with PCCi if they are unsatisfied with the services received. PCCi encourages resolution of complaints at the lowest level. Often a conversation between the complainant and involved staff member(s) is sufficient to satisfy the concerned party. However, if the complaint is not resolved to mutual satisfaction, the complainant is encouraged to complete the Client Grievance form and engage in the grievance process.

1. Individuals will be notified of the Grievance Policy and Procedure upon intake by receiving a written copy of the policy.
2. Client Grievance forms can be found in the lobbies of both buildings on the PCCi campus.
3. When a grievance is filed, staff will assist complainants (as applicable) to understand and complete the grievance process and notify them of the results and basis for the decision.
4. Resolution of the grievance will be facilitated at the lowest possible level.
5. If this matter is likely to cause harm to the individual filing the complaint, the individual may request an expedited review and receive a response in writing within 48 hours of receipt of the grievance.
6. Grievance Timelines:
    a. The Clinical Director and Executive Director will meet and investigate the grievance within 5 working days of PCCi receiving it and will document the investigation on the Grievance Investigation form.
    b. PCCi will issue a response to the grievance within 5 working days of the Clinical Director and Executive Director completing their investigation.
        i. If the grievance is substantiated PCCi will:
            1. Contact the complainant with a proposed/appropriate plan of action.
            2. If complainant approves of the plan of action, PCCi will take the necessary steps to carry out the action plan.
            3. If complainant does not approve of the plan, then the complainant will be encouraged to file an appeal.
            4. A copy of the Client Grievance form and all following documentation will be placed in the staff member's personnel file.
        ii. If the grievance is unsubstantiated PCCi will contact the complainant with the rationale behind this decision. If the complainant is unsatisfied, the complainant will be encouraged to file an appeal.
7. All grievance forms, investigation forms, and responses will be reviewed quarterly by the Quality Improvement Committee (QIC).
    a. If the QIC disagrees with the response issued in an unsubstantiated grievance, then the QIC will design an action plan to be proposed to the complainant. The Executive Director will contact the complainant and present the new action plan.
    b. If the QIC disagrees with the response issued in a substantiated grievance, the QIC will document their disagreement in writing.
    c.
    d. Any action plans and/or responses issued by the QIC will be placed in the staff member's personnel file.
8. All grievance forms, investigation forms, and responses will be kept in a locked file cabinet in the Executive Director's office.

9. The complainant shall be free from retaliation resulting from this complaint. Complainant shall also be free from any civil or criminal liability with respect to making or the content of a grievance.
10. The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

Grievance Procedure

Any individual receiving services, or the parent/guardian of the individual receiving services, may file a grievance with the provider, the managed care plan, or the Division of Addictions and Mental Health. Numbers are listed below.

In order to file a grievance at PCCi:

1. Complete a Client Grievance form, available in the lobbies of both buildings on the PCCi campus.
2. The Clinical Director and Executive Director will meet and investigate the grievance within 5 working days of PCCi receiving it.
3. PCCi will issue a response to the grievance within 5 working days of the Clinical Director and Executive Director completing the investigation.
4. If this matter is likely to cause harm to the individual filing the complaint, the individual may request an expedited review and receive a response in writing within 48 hours of receipt of the grievance.
5. If the complainant is not satisfied with the decision, they may file an appeal in writing within 10 working days of receiving PCCi's response to the initial grievance. The appeal must be submitted to the CMHP Director in the county where the provider is located or to the Division as applicable.
6. If the complainant is not satisfied with the appeal decision, he/she may file a second appeal in writing within 10 working days of the date of the written response to the Director.

Important Numbers:

- Division of Addictions and Mental Health (AMH) – 503-945-6182
- Director of Addiction Services Jackson County -541-774-7800
- Disability Rights Oregon -1-800-452-1694
- Care Oregon – 1-800-224-4840
- Oregon Health Plan (OHP)- 503-945-5772

For additional information, please see: Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 428.205 - 428.270, 430.640
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.430 - 409.435, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

DUII Policies

Phoenix Counseling Center
Counseling from the heart

Medical Marijuana Policy

In accordance with state regulations, Phoenix Counseling Center cannot allow the use of medical marijuana by individuals in the DUII program.

Levels of Care

Level of care is determined by a combination of the following: information gathered at assessment; recommendation on the individual's ADES form sent to PCCi by DUII services; and the initial UA provided at assessment.

If assessed at Level 0.5, individuals will be expected to complete 7 weeks (14 hours) of DUII education groups as well as 3 individual sessions after the assessment. They will also be expected to provide observed UAs at random times throughout their 7 week treatment. If an individual has been diagnosed with a substance use disorder (moderate or severe) in the past or if they have had a previous DUII, they may not be assessed at level 0.5. **If any UAs are positive for any unprescribed substances (individuals must provide PCCi with a copy of their prescriptions), level of care will be increased to Level 1.**

If assessed at Level 1 treatment, individuals will attend the 7 week education groups as well as weekly individual sessions. After completion of the education groups, a new group will be added to the individual's service plan for the remainder of the **required 90 day abstinence period which begins with the individual's first negative UA.** UAs will be provided during this entire period. If any UA during treatment is positive for any unprescribed substance, the 90 abstinence period restarts on the date of the next negative UA.

If assessed at a higher level of care, the individual will complete the 7 week education group at some point during their treatment.

Please note: If the initial UA (at assessment) is positive for any unprescribed substance, the individual is automatically assessed at Level 1 (or higher) as per State regulations.

Attendance

Phoenix Counseling Center requires consistent attendance in the DUII program for successful completion. It is expected that individuals have a face-to-face interaction every week while in the DUII program. If an absence is pre-arranged, a UA must be provided within the same week of the missed group. If a group is missed without prior arrangement, a UA must be provided within 24 hours of the missed group. In the event that this UA is not provided, an additional weekly group will be added to the individual's service plan for the remainder of their treatment.

The State of Oregon requires at least one UA every 14 days. If the period between UAs is greater than 14 days, the 90 day abstinence period will restart.

Revised 4-2019

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Phoenixcounseling.org

EMERGENCY CONTACTS

Helpline
541-779-HELP (4357)
1-888-609-HELP

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

Jackson Co. Mental Health Crisis Services
541-774-8201

Sexual Assault Victim Services (SAVS):
Hotline: 541-779-4357 or 855-216-2111

Ashland Community Hospital:
541-201-4000
280 Maple Street, Ashland

Rogue Regional Medical Center:
541-789-7000
2825 East Barnett, Medford

Providence Medford Medical Center:
541-732-5000
1111 Crater Lake Ave., Medford

Revised 10-2017

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Urinalysis (UA) Testing

Below is a list of items that may result in a positive UA. It is in your best interest to avoid all of them.

Substances to avoid completely (could cause a positive UA):

1. Alcohol of any kind
2. Street drugs, including marijuana. We do NOT accept medical marijuana.
3. Prescription drugs, unless you can provide a prescription and your doctor's name and phone number.

Substances that could show up in trace levels in your UA:

1. Kratom
2. Anything that contains alcohol or medical marijuana (sauces, marinades, etc.)
3. Poppy seeds
4. Mouthwash. Use alcohol-free.
5. Tinctures. Use alcohol free.
6. Kombucha tea. It's fermented – avoid all fermented substances.
7. Over the counter cough and cold remedies – including Ny-Quil. They contain dextromethorphan which can show up as an opiate.
8. Nyquil or Day-Quil
9. Breath spray
10. Non-alcoholic beer. It tests positive!
11. Smoking tobacco out of a pipe used for any other drugs
12. Hemp cosmetics, hair products, or lotion
13. Bumming cigarettes from people who might dip them in THC oil or roll them with marijuana shake
14. Flavored extracts for baking that you do not cook
15. Essential oils made with alcohol or THC
16. Hemp
17. Over the counter medication with alcohol or ephedrine in it
18. Diet pills
19. Albuterol breathing treatments

Be sure to read the labels on products, food and drink to be sure they are free of any of these substances.

Dilute UAs

Drinking too much liquid can result in a diluted UA reading. You may be asked to provide an additional UA. Drink enough fluid to stay hydrated but try not to drink more than you normally do.

Revised 10-2017

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

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.

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 am 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 care 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.)

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.)

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) and Date]

_____

[Signature of Witness (Printed Name) and 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 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 pail 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.