The Northwest Catholic Counseling Center
8383 NE Sandy Blvd, Suite 205
Portland, OR 97220
(503) 253-0964
www.nwcounseling.org

Welcome Letter

Welcome to The Northwest Catholic Counseling Center (NCC). Choosing to begin or continue this journey into yourself is an incredible act of courage, strength, and hope. Our commitment is to celebrate those qualities in you, provide you with a safe environment to express yourself without judgement, and to build a trusting therapeutic relationship that will support you in achieving your goals.

New Client Paperwork

- The documents contained in your client **Orientation Packet** are for ***informational purposes only***. You are not required to complete any forms in the Orientation Packet in order to begin services. Please take time to review all documents and don't hesitate to reach out to your clinician with any questions or concerns. You have received either a paper or electronic copy of your Orientation Packet that you may refer back to at any time.
    - Orientation Packet documents include:
        1. Client Welcome Letter
        2. Declaration for Mental Health Treatment Information & Form
        3. Individual Rights and Responsibilities
        4. Grievance and Appeal Policy & Form
        5. Notice of Privacy Practices
        6. Oregon Voter Registration Information & Form
        7. Telehealth Services Policy
        8. Communicable Disease Risk and Prevention Policy
        9. Fee Agreement Policy
        10. Good Faith Estimate Chart
- The documents contained in your client **Intake Packet** ***must be completed and returned*** to your clinician prior to your first appointment.
    - Please submit the required forms using one of the following formats:
        - Log into your client portal using the login information that will be sent to your email address by our portal system, DrCloudEMR. Follow the instructions to complete required Intake Packet forms and upload a copy of your photo identification and insurance cards; **OR**
        - Contact your clinician to schedule to arrive 1 hour early to your first appointment and complete the paperwork in our lobby. Please bring your photo identification and insurance cards.
    - Intake Packet documents include:
        1. Informed Consent to Treatment Services
        2. Fee Agreement
        3. Billing Authorization
        4. Psychosocial Questionnaire
        5. General Anxiety Disorder Assessment (GAD-7)
        6. Patient Health Questionnaire (PHQ-9)
        7. Posttraumatic Stress Disorder Checklist (PCL-5)
        8. Your clinician's Professional Disclosure Statement (PDS)
    - Intake Packet documents considered 'as needed' that your clinician may add to your packet include:
        - Graduate Intern Clinician Informed Consents
        - Authorization for Release of Information
        - Financial Assistance Eligibility
        - Third-Party Payor Authorization

Services

- Counseling services are scheduled by appointment, Monday through Friday 9am to 5pm, with some evening availability. Services are offered in-office and via telehealth.
- Appointments are generally 50-60 minutes in length, unless otherwise arranged with your clinician. Our session frequency is estimated to start at once per week, then every other week, and so on for a total of 24-36 sessions. However, please note that your clinician may reassess your specific needs at any time during the course of treatment and recommend an adjustment to this session frequency/duration.
- NCC employs Licensed Professional Counselors, Professional Counseling Associates, Licensed Clinical Social Workers, Clinical Social Worker Associates, and Graduate Student Interns. All of our clinicians are licensed and/or registered with the appropriate Board and receive required clinical supervision.
- If you wish to terminate care with your clinician for any reason, please notify them before your last session so that they may prepare to support you with an aftercare plan and referral to other clinicians who may better fit your needs. If your clinician needs to terminate care for any reason, you will be contacted as soon as possible with a referral to other clinicians who they anticipate will meet your needs.

Confidentiality

- Your privacy, safety, and trust are important to us. All client records, as well as information discussed in clinical sessions, are kept confidential. Exceptions to this are detailed in our Notice of Privacy Practices, which is provided to you in the NCC Orientation Packet.
- If you have an additional mental health professional or a legal guardian involved in your care, we will suggest that you complete the Authorization for Release of Information form so that we may coordinate care.
- Our staff does not accept contact requests from current or former clients on any social networking sites.

Grievance and Appeal

- It is your right and responsibility to communicate with NCC staff any concerns you have regarding your treatment. We strive to ensure all concerns are addressed as quickly, simply, and fairly as possible.
- Please review our Grievance and Appeal Policy found in the NCC Orientation Packet for guidance on how to file a grievance or appeal, if the need should ever arise.

Payment and Fees

- NCC is an independent non-profit organization that has been able to provide affordable mental health services to those in need due to the ongoing generosity of community donors and former clients. That being said, the payment of client fees also plays a critical role in keeping our organization – and our mission – alive.
- Therefore, payment is due at the time of service. If you are experiencing financial hardship, please let us know and we would be happy to discuss financial assistance. There is a $20.00 charge for all returned checks or stopped payments on debit/credit cards.
- If you choose to use your insurance, we will make every effort to bill them using the information we have on file. It is your responsibility to notify us of changes to your insurance and to pay any remaining balance your insurance does not cover (e.g. deductible, copay, coinsurance, etc.).
- Appointments must be canceled or rescheduled at least 24 hours in advance to avoid a $50 late cancellation fee. Additionally, your treatment may be paused after 3 consecutive 'no shows', so please make a commitment to attend your sessions regularly.

Emergencies

- If you experience thoughts of harming yourself or someone else, please notify your clinician as soon as possible so that they can develop a plan with you to maintain your safety. In the case of a mental health crisis, please visit your nearest urgent care clinic or contact one of the support hotlines below:
    - Crisis Text Line: Text OREGON to 741741
    - Lines for Life Hotline: 800-273-8255
    - Multnomah County Crisis Line: 800-716-9769

Thank you for taking the time to review these policies. We look forward to working with you.

Respectfully,
The Northwest Catholic Counseling Center

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Declaration for Mental Health Treatment Information

Below you will find information on the Declaration for Mental Health Treatment.

If you would like to complete the voluntary Declaration for Mental Health Treatment form, you can find an electronic copy in your client portal under the "Clinical Forms" tab or a paper copy in your Orientation Packet, in our lobby, or as requested from any NCC staff.

Please speak with your clinician for additional support in completing this form, if needed.

- The Mental Health Treatment Declaration form is a legal document through the state of Oregon that allows you to make decisions now about future mental health care in case you are unable to make your own care decisions.
- Only a court and two doctors can decide that you cannot make your own care decisions.
- You may also use this form to name an adult who can make mental health choices for you when you cannot make them for yourself.
- This person must agree in writing to represent you. The person you name must follow your wishes. If no one knows your wishes, the person you name must make them for you. They must make decisions that are in your best interest.
- A Declaration of Mental Health Treatment is good for three (3) years. If you become unable to make decisions, this document will remain in effect until you are able to make your own decisions.
- You may change or cancel your Declaration at any time as long as you are capable of making decisions for yourself.
- It is important to give your completed form to your clinician and a copy to the person who represents you.
- For more information on the Declaration for Mental Health Treatment, go to the State of Oregon's website at: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9550.pdf

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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:

_____ _____

Printed Name & Signature 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:

_____ _____

Printed Name & Signature of Witness Date

_____ _____

Printed Name & Signature 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.

_____ _____

Printed Name & Signature of Representative 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.

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Individual Rights and Responsibilities

Every individual receiving services at The Northwest Catholic Counseling Center has the right to:

1. Be informed at the start of services and periodically thereafter of these rights;
2. Be free from discrimination on the basis of race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age, familial or marital status, income, and disability;
3. Be treated with dignity, respect, and compassion and to have religious freedom;
4. Receive services that are culturally competent, trauma-informed, and evidence-based in a safe, clean, and comfortable setting;
5. Receive services 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;
6. Receive services in the timeliest manner feasible consistent with the presenting circumstance;
7. Be informed of NCC's Policies and Procedures, service agreements and fees applicable to the services provided, and to have a representative assist with understanding any information presented;
8. Receive written program orientation information in a language understood by the individual;
9. Have all services explained, including expected outcomes and possible risks;
10. 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 at age 14 or older);
11. Participate in the development of a written service plan, receive a copy, receive services consistent with the plan, and participate in periodic review and reassessment of service needs;
12. Have family and guardian involvement in service planning and delivery;
13. Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to safety;
14. Inspect their service record in accordance with ORS 179.505;
15. Be assured of privacy and confidentiality in accordance with Oregon ORS, HIPAA, and 42 CFR Part 2;
16. To have the appropriate Board confirm the credentials of your clinician;
17. File grievances, including appealing decisions resulting from the grievance;
18. Refuse treatment and/or participation in experimentation;
19. Be free from seclusion or restraint as a means of coercion, discipline, convenience, or retaliation;
20. Be free from abuse or neglect and to report any incident of abuse or neglect;
21. Exercise all rights, including those set forth in ORS 109.610 - 109.697 if the individual is a child under age 14 and ORS 426.385 if the individual is committed to the Authority, without any form of reprisal.

Every individual receiving services at The Northwest Catholic Counseling Center has a responsibility to:

1. Provide accurate and complete information;
2. Request clarification if information provided to you is not fully understood;
3. Notify your clinician if you have any concerns about your treatment; and
4. Make the necessary arrangements for NCC to receive payment for services rendered to you.

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Grievance and Appeal Policy

If you would like to submit a Client Grievance and Appeal Form, you can find an electronic copy in your client portal Orientation Packet or on our website at nwcounseling.org. If you would like to submit a paper form, you can find a copy in your paper Orientation Packet, in our lobby, or as requested from any NCC staff.

The Northwest Catholic Counseling Center (NCC) is committed to providing professional treatment services which adhere to all applicable laws, policies, and procedures. It is your right and responsibility to communicate with NCC staff any concerns you have regarding your treatment. We strive to ensure all concerns are addressed as quickly, simply, and fairly as possible. Please review the following Grievance and Appeal Policy for guidance on how to file a grievance or appeal, if the need should ever arise.

Please note that a grievant, witness, or staff member may not be subject to retaliation, discrimination, or any other penalty by NCC for making a report or being interviewed about a grievance or being a witness. The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith. Grievances are kept confidential in accordance with applicable laws and NCC Policies and Procedures. Grievances and appeals are recorded in a confidential log maintained by the Clinical Manager and is subject to review by the Oregon Health Authority – Health Systems Division.

- **Grievance** – An expression of dissatisfaction about any matter regarding your treatment.
  - Step 1: Informal Grievance
    1. Try to resolve the issue at the informal level by talking to those who are directly involved and best able to help; for example, the clinician or other staff person.
    2. If this is undesirable or unsuccessful, ask to speak with that person's supervisor.
    3. If the problem is not resolved at the supervisor level, ask to speak with the Executive Director.
  - Step 2: Formal Grievance
    1. If the issue cannot be resolved informally, you may file your grievance at any time in writing using the Client Grievance and Appeal Form.
    2. The form must be fully completed, signed, and dated in order to be accepted.
    3. Submit your completed form in person or via USPS mail to The Northwest Catholic Counseling Center, 8383 NE Sandy Blvd, Suite 205, Portland, OR 97220.
    4. You may authorize a legal representative to act on your behalf in the grievance or appeal process.
  - Step 3: NCC Response
    1. You or your legal representative will be sent written confirmation within 3 business days of when your grievance has been received by the designated NCC staff (see below):
       a. The Clinical Manager will oversee the grievance process. If the grievance involves the Clinical Manager, the Executive Director will oversee the process. If the grievance involves the Executive Director, the grievance will be processed by the NCC Board of Directors.

2. The designated NCC staff will complete their investigation within 30 calendar days after the receipt of your grievance.
3. The designated NCC staff will send you or your legal representative a written response within 3 business days of reaching a decision. The written response will summarize the investigation process, findings, decision, and action plan, if applicable. The written response will also include information about the appeal process.

- **Appeal** – A request to have a decision reviewed and changed because you are not satisfied with the decision.
  1. If you or your legal representative are not satisfied with the decision, you may file an appeal in writing within *10 business days* of the date of NCC's written response. Please complete a new Client Grievance and Appeal Form and use the instructions above in the 'Grievance' section when submitting your appeal.
     a. The Executive Director will oversee the appeal process. If the Executive Director had previously investigated and responded to your grievance, the appeal will be processed by the NCC Board of Directors.
  2. The designated NCC staff will complete their investigation within 30 calendar days after the receipt of your appeal.
  3. The designated NCC staff will send you or your legal representative a written response within 3 business days of reaching a decision. The written response will summarize the investigation process, findings, decision, and action plan, if applicable.
  4. If the NCC Board of Directors had previously investigated and responded to your grievance, you may submit an Oregon Health Authority (OHA) Complaint Form on their website for a follow up investigation.
     a. The OHA Health Systems Division (HSD) will make every effort to resolve your complaint within 30 days. Once all the necessary information has been gathered and reviewed, HSD will send you a resolution letter to communicate the resolution and any next steps. If you or your legal representative are not satisfied with the appeal decision, you may file a second appeal in writing within ten working days of the date of the written response to the Division Director.

- **Expedited Grievance**

  In circumstances where the matter of the grievance is likely to cause harm to you before the grievance procedures are completed, you or your legal representative may request an expedited review.

  The designated NCC staff shall review and respond to the grievance within 48 hours of receipt of the grievance. The written response will include information about the appeal process.

- **Helpful Contact Information**

  a. OHA Health Systems Division – (503) 945-5763

  b. Disability Rights Oregon – (503) 243-2081

  c. HealthShare of Oregon – (503) 416-8090

  d. Governor's Advocacy Office – (503) 945-6904

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Client Grievance and Appeal Form

Submit your completed Grievance and Appeal Form in person or via USPS mail to:
The Northwest Catholic Counseling Center, 8383 NE Sandy Blvd, Suite 205, Portland, OR 97220

I wish to file (choose one): ☐ Grievance ☐ Appeal ☐ **Expedited Grievance*

**NOTE: Please see the requirements for an Expedited Grievance in the NCC Grievance and Appeal Policy*

Name and DOB: _____ Today's Date: _____

Relationship to Client: _____ Phone Number: _____

Mailing Address: _____

Client's Name and DOB (if not completing form): _____

Date/Time of Incident: _____ Individual(s) Involved: _____

Briefly describe the issue(s) that prompted this grievance/appeal (attach additional sheets as necessary):

Briefly describe any actions you have taken to resolve the issue:

Briefly describe what you believe would be a satisfactory resolution:

I have read and understand the NCC Grievance and Appeals Policy. I certify that the information I have entered above is true and correct, to the best of my knowledge.

_____ _____

Signature of Individual Completing Form Date

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Notice of Privacy Practices

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

Our Duty to Safeguard Your Protected Health Information

Identifiable information about your past, present, or future health, the provision of health care or payment for health care is considered "Protected Health Information" (PHI). We are required to extend certain protections to your PHI and give you this notice about privacy practices that explain how, when, and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

You have been provided a copy of this notice in your Orientation Packet prior to beginning services. Additional copies of this notice are available in the waiting room and on our website at www.nwcounseling.org.

How We May Use and Disclose Your Protected Health Information

We use and disclose PHI for a variety of reasons. We have a limited right to use and/or disclose your PHI for purposes of treatment, payment, and for our health care operations. For uses beyond that, we must have your written authorization. If we disclose your PHI to an outside entity to perform a function on our behalf, we must have in place an agreement from that entity that it will extend the same privacy protection to information that we must apply to your PHI. However, the law provides that we are permitted to make some disclosures without consent or authorization. The following describes and offers examples of our disclosures of your PHI.

- For Treatment: We may disclose your PHI to doctors or other health care personnel who are involved in providing your health care.
- To Obtain Payment: We may disclose your PHI in order to bill and collect payment for your health care services.
- For Health Care Operations: We may be required to provide information to a government agency for study. This is highly unlikely but if it were to occur, your name will be removed from what is sent.

Uses and Disclosures of PHI Requiring Authorization

For disclosures beyond treatment, payment, and operations purposes we are required to have your written authorization, unless the disclosure falls within one of the exceptions described below. Authorization can be revoked at any time to stop future disclosures except to the extent that we have already acted upon your authorization.

Uses and Disclosures of PHI from Mental Health Records Not Requiring Consent

- When Required by Law: We must disclose PHI to report suspected abuse, lawsuits, or other legal proceedings where we have received a subpoena and to government agencies monitoring HIPAA compliance.

- To Avert Threat to Health or Safety: In order to avoid a serious threat to health or safety, we must disclose PHI as necessary to law enforcement or other persons who can reasonably present or lessen the threat of harm.

- For Specific Government Functions: We must disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment, Worker's Compensation programs and for national security.

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- To Request Restrictions to Disclosures: You have the right to ask that we limit how we disclose your PHI. We will consider your request, but are not legally bound to agree. To the extent that we do agree, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit disclosures that are required by law.

- To Inspect and Request a Copy of Your PHI: Unless access to your records is restricted for clear and documented treatment reasons, you have a right to see your PHI upon written request. If you request copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied.

- To Request Amendment of your PHI: If you believe there is a mistake or missing information in your PHI, you may request, in writing, that we correct the record. We will respond within 60 days. We may deny the request if we determine the PHI is: 1. Correct and complete; 2. Not created by us; 3. Not permitted to be disclosed. Any denial will state the reason for denial.

- To Find Out What Disclosures Have Been Made: You have a right to receive a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; to you, your family, or pursuant to your written authorization. Your request can relate to disclosures going as far back as seven years.

- Couples Counseling: In regard to couples counseling, confidentiality belongs to both parties. No information will be released unless a signed consent form is received from both parties.

If you believe we have violated your privacy rights you may file a complaint with the person listed below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. A complaint will not affect your quality of care with us.

If you have questions about this notice, please contact our Privacy and Security Officer at (503) 253-0964. Our ethical commitment to your privacy goes beyond federal law. We will make every effort to inform you of routine disclosures.

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Oregon Voter Registration Information

Below you will find information on voter registration in the state of Oregon.

If you would like to register to vote, please use the link below, obtain a paper form from our lobby, or request a paper form from NCC staff. Please speak with your clinician for additional support in registering to vote, if needed.

1. Am I registered to vote?
   - Check or update your voter registration. Please note, if you are under 18 years old or a confidential voter, you will not be able to check the status of your registration online. If you recently registered, your information may not show online yet. To verify your registration status, please call 503-988-VOTE (8683).
2. How can I register to vote?
   - Register to vote online using the Oregon Secretary of State's My Vote if you are at least 16 years old, a resident of Oregon, and a citizen of the United States. An Oregon driver's license or state ID card issued by the Oregon Department of Motor Vehicles (DMV) is required to register online.
   - If you do not have an Oregon Drivers License please print and fill out a paper voter registration form (links below), sign the form, and return it by mail or deliver in person. Please do not email your original paper registration card. The original paper registration is a requirement under Oregon law. *If you do not have a printer please call Multnomah County Elections at 503-988-VOTE (8683). You can also get a paper registration form at your local U.S. Post Office or public library.*
     - Fillable PDF Oregon voter registration - English
     - Fillable PDF Oregon voter registration - Español Spanish
     - Fillable PDF Oregon voter registration - 中文 Chinese
     - Fillable PDF Oregon voter registration - Tiếng Việt Vietnamese
     - Fillable PDF Oregon voter registration - Soomaali Somali
     - Fillable PDF Oregon voter registration - русский Russian
   - Information for voters experiencing housing instability or houselessness. Yes, you can still register to vote if you don't have a permanent address.
3. How can I update my registration?
   - Address change - If you are already registered in Oregon and only changing your residence or mailing address (local or overseas), update your address here.
   - Party affiliation change - Update your party affiliation by completing a new registration card online or print.
   - Name change - Complete a new print registration card so that we have your new signature on record.
4. Where can I find voter registration cards?
   - At your county elections office
   - Post Offices
   - Libraries
   - DMV Offices

Oregon Voter Registration Card

Clear Form | Print | Save As

SEL 500 rev 3/22

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
4500 SW Research Way, 2nd Flr
Corvallis OR 97333-1093
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
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 Ave, 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
PO Box 100
Albany OR 97321-0031
541 967 3831

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

Marion County
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 8683

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 2374

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

The Northwest Catholic Counseling Center
8383 NE Sandy Blvd, Suite 205
Portland, OR 97220
(503) 253-0964
www.nwcounseling.org

Telehealth Services Policy

Telehealth involves the use of electronic communications through audio and video technologies to enable health care providers at different locations to provide mental health care and to receive medical information for the purpose of assessment and provision of mental health services. Providers may utilize telehealth to conduct assessments, provide therapy, and the information shared may be used for diagnosis, therapy, follow-up and/or education.

Telehealth Rights

- I understand that the laws that protect privacy and limitations with confidentiality of mental health information also apply to telehealth. The right to confidentiality while receiving electronic services has the following exceptions: 1) in cases or suspicion of child abuse or neglect or elder abuse or neglect; 2) in cases or suspicion of imminent harm to yourself or others; 3) the reporting of information required by court system, insurance companies, or relevant agencies, 4) clinical supervision and/or consultation conducted through in-person or electronic communications.
- I can withhold or withdraw my consent to the use of telehealth at any time. I understand withdrawal of telehealth services may interrupt or impact my ability to receive treatment.
- I understand that my provider has the right to withhold or withdraw his, her, or their consent for the use of telehealth at any time. Providers may withdraw consent due to there being a need for a higher level of care or telehealth services may be influencing risks around privacy and safety.
- I understand that Oregon's Social Work and Counseling licensing or Associate rules and regulations that apply to mental healthcare practices also apply to telehealth counseling services.
- I understand that due to the nature of telehealth counseling, providers cannot guarantee confidentiality of your direct environment.
- Telehealth sessions will not be recorded without my written consent.
- I understand that technical difficulties may occur before or during the telehealth sessions and my appointment may not start or end as intended.

Telehealth Responsibilities

- I will enter a confidential space prior to the start of our session or inform my provider if any other person can hear or see any part of our session.
- I am responsible for the configuration of any technology used on my phone, tablet, or computer which is used for telehealth.
- I am responsible for being physically in the state my provider is registered or licensed in at the time of service.
- I am responsible to attend session without being under the influence of alcohol or substances or utilizing substance while in session.
- Telehealth sessions are not to be recorded without written consent from my provider.
- I understand that my insurance may impose restrictions on the type of technologies that may be used and that my insurance may not cover the additional fees of the telehealth practices, which I may be responsible for any fee that my insurance company does not cover.
- I accept that I must be present for therapy and I must not be operating a vehicle or multi-tasking while in session.
- I understand that I may need to change in-person services to telehealth format at any time of a health crisis or pandemic. Refusal to transition to telehealth services may interrupt or impact my ability to receive treatment.
- I understand that If I am unwell and have current symptoms of illness, I will need to utilize telehealth.
- I understand that if my provider is symptomatic and able to provide services, they will communicate the need to transition from in-person to telehealth or reschedule for next available in-person appointment.

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Communicable Disease Risk & Prevention Policy

The Communicable Disease Risk and Prevention Policy is provided to all staff in their Employee Handbook, to clients in their Orientation Packet prior to beginning services, and is also made available in the NCC lobby for visitors.

This policy describes a core set of infection prevention and control practices, also called Standard Precautions, that are required in all healthcare settings, regardless of the type of healthcare provided. Adherence to this policy is essential to providing safe and high-quality client care.

This policy applies to all clients, staff, volunteers, and visitors, regardless of diagnosis or presumed infection status. All staff are responsible for understanding the principles of infection control, assessing situations, and implementing the Standard Precautions as noted below.

Standard Precautions include:

1. **Hand hygiene**
    a. Hand hygiene is practiced before and after contact with individuals and all body substances whether or not gloves are used.
    b. If hands come in contact with blood or body fluids, they are washed immediately with soap and water or an alcohol-based hand rub.
2. **Environmental cleaning and disinfection**
    a. Frequently touched surfaces, as well as any other surfaces in close proximity to clients and staff, shall be cleaned and disinfected daily.
    b. Any known contamination of spaces or items with potentially infectious materials, such as bodily fluid, shall be disinfected immediately while wearing gloves.
3. **Use of personal protective equipment**
    a. All clients and staff shall have access to Personal protective equipment (PPE) in common areas and upon request, including gloves and masks.
    b. The provided PPE is recommended when in a closed space in close proximity (6 feet or less) to another individual, regardless of diagnosis or presumed infection status.
    c. The provided PPE is required to be utilized when contact with bodily fluid or airborne pathogens is anticipated.
4. **Respiratory hygiene and cough etiquette**
    a. Please use precautions when coughing or sneezing by covering your mouth, using tissues, wearing a mask (if possible), and using hand sanitizer. Tissues, masks, and hand sanitizer are all provided to you in common spaces around NCC.
    b. Staff, clients, and visitors showing symptoms of a respiratory infection will be asked to leave until symptoms have improved.
    c. In the case of client appointments, clients are encouraged to speak with their clinician about changing their session to telehealth or rescheduling as needed.
    d. If the symptoms of infection are consistent with COVID-19, the individual will be required to isolate for no less than 5 days before returning.
    e. Ventilation devices shall be used during CPR.
5. **Sharps safety**
    a. If you should encounter a needle or other item that can be presumed to have had contact with blood, notify staff (or your supervisor) immediately. Do not touch the item.

During periods of higher levels of community respiratory virus transmission, NCC shall require all clients, staff, and visitors to mask upon entry to ensure better adherence to respiratory hygiene and cough etiquette for those who might be infectious. Clients shall be notified of this requirement so appointments can be changed to telehealth, if needed. In the event of a public health emergency, NCC will follow the recommendations of the CDC/state epidemiologist regarding use of PPE, social distancing, and other precautions.

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Fee Agreement Policy

CLIENT FORMS

- Prior to receiving services, all clients shall review the following:
  - Fee Agreement Policy, which outlines NCC's financial policies as they pertain to clients.
  - Good Faith Estimate document, which lists the expected costs for our services.
- Prior to receiving services, and if financial information changes, all clients shall sign the following:
  - Fee Agreement form, which obtains client's agreement to pay fees for services rendered to them.
  - Billing Authorization form, which obtains client's authorization for NCC to bill and receive payment.
- Prior to receiving services, and if financial information changes, clients may complete the following as needed:
  - Financial Assistance Eligibility form, which determines client's eligibility to receive a fee discount based on financial hardship.
  - Third-Party Payor Authorization form, which obtains a third-party payor's authorization for NCC to bill them and receive payment on behalf of the client.
  - Payment Plan Agreement form, which outlines an individualized payment plan to pay down an outstanding balance.

FEES AND PAYMENT

- Payment is due at the time of service.
- NCC accepts cash, debit/credit cards, checks, and electronic payments through client portal or nwcounseling.org. Clients may also keep a debit/credit card on file for automatic payments.
- There is a $20.00 charge for returned checks or stopped payments on debit/credit cards.
- If a client's past due balance exceeds 3 sessions, a payment must be received before scheduling additional appointments. Clients may contact our billing department to set up a Payment Plan, if needed.

LATE CANCELLATION POLICY

- When a session is cancelled without adequate notice, NCC is unable to offer the appointment slot to another client. In addition, NCC is unable to bill insurance for sessions that are not kept.
- Therefore, if cancellation of an appointment is not received at least 24 hours in advance, the client will be charged $50 (or a percentage of $50 based on Financial Assistance Eligibility).

THIRD-PARTY PAYORS

- Third-party payors include health insurance providers, workers' compensation/employers, and family members other than the client's primary guardian.
- NCC will make every effort to bill the client's third-party payor using the information we have on file. It is the client's responsibility to notify NCC of changes to their third-party payor's information.
- Third-party payors may pay all, a portion, or none of a client's bill for services. Clients are responsible for their deductible, copay/coinsurance, as well as any other fees the third-party payor does not cover.
- Clients are encouraged to contact their insurance provider directly for questions regarding their coverage.

SELF-PAY

- Clients are considered "Self-Pay" if they do not have insurance or elect not to use their insurance.
- Self-Pay clients have the right to request and receive a Good Faith Estimate for the expected cost of services.
- Treatment frequency and duration is estimated to be 1-4x/mo, 50 min per session, for 24-36 sessions. These estimates may vary throughout the course of treatment, as agreed upon by the client and their clinician.
- Good Faith Estimates cannot include unexpected costs or special circumstances that arise during treatment.
- For questions regarding Good Faith Estimates, visit www.cms.gov/nosurprises/ or call (800) 985-3059.

FINANCIAL ASSISTANCE

- In the event of financial hardship, Self-Pay clients are encouraged to contact the NCC billing department to complete a Financial Assistance Eligibility form.
- Financial Assistance Eligibility is re-evaluated quarterly and clients without insurance shall be requested to show proof of application submission for Medicaid/OHP to continue on financial assistance.
- Self-Pay clients are responsible for payment of NCC's standard counseling fees for services rendered prior to signing an updated Fee Agreement form stating a financial assistance discount.

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Good Faith Estimate

NCC Standard Counseling Fees

Appointment Type	CPT Code	Fee Per Service
Initial Assessment	90791	$250
Individual Psychotherapy (16-37 min)	90832	$150
Individual Psychotherapy (38-52 min)	90834	$200
Individual Psychotherapy (53+ min)	90837	$250
Family/Couple Psychotherapy (with or without client present)	90846 or 90847	$200
Crisis Services	90839	$150
No Show/Late Cancellation Fee	N/A	$50

**Note: Appointment duration is estimated to be 50-60 minutes (CPT Code 90834 or 90837)*

NCC Financial Assistance Sliding Scale

			Discounted Fee Per Service						
Tier Level	FPL	Fee Discount	90791	90832	90834	90837	90846 or 90847	90839	No Show/Late Cancellation
6	0-50%	99%	$3	$1	$2	$3	$2	$1	$1
5	51-100%	94%	$15	$9	$12	$15	$12	$9	$3
4	101-150%	88%	$30	$18	$24	$30	$24	$18	$6
3	151-200%	80%	$50	$30	$40	$50	$40	$30	$10
2	201-250%	70%	$75	$45	$60	$75	$60	$45	$15
1	251-300%	58%	$105	$63	$84	$105	$84	$63	$21
N/A	301% +	N/A	$250	$150	$200	$250	$200	$150	$50

**Note: Based on the 2025 FPL Guidelines Chart below*

2025 Federal Poverty Level (FPL) Guidelines

Household Size	50%	100%	150%	200%	250%	300%
1	$652.08	$1,304.17	$1,956.25	$2,608.33	$3,260.42	$3,912.50
2	$881.25	$1,762.50	$2,643.75	$3,525.00	$4,406.25	$5,287.50
3	$1,110.42	$2,220.83	$3,331.25	$4,441.67	$5,552.08	$6,662.50
4	$1,339.58	$2,679.17	$4,018.75	$5,358.33	$6,697.92	$8,037.50
5	$1,568.75	$3,137.50	$4,706.25	$6,275.00	$7,843.75	$9,412.50
6	$1,797.92	$3,595.83	$5,393.75	$7,191.67	$8,989.58	$10,787.50
7	$2,027.08	$4,054.17	$6,081.25	$8,108.33	$10,135.42	$12,162.50
8	$2,256.25	$4,512.50	$6,768.75	$9,025.00	$11,281.25	$13,537.50
9	$2,485.42	$4,970.83	$7,456.25	$9,941.67	$12,427.08	$14,912.50
10	$2,714.58	$5,429.17	$8,143.75	$10,858.33	$13,572.92	$16,287.50

**Note: Based on gross monthly income and issued by the Department of Health and Human Services (HHS)*