NPFS
NEW PRIORITIES FAMILY SERVICES
With hope, with change, brings new life.

1655 SW Highland Ave Suite 3, Redmond, OR, 97756 | (P)541.923.2654 | (F)541.548.8099

Client Information

Individual's Name:_____ Email:_____
Address:_____ City/Zip:_____
Phone:_____ Cell_____ Home ODL/ID#:_____
DOB:_____ Age:_____ Sex:_____ Social Security Number:_____
Gender Identity:_____ Sexual Orientation:_____ Race:_____
Ethnicity:____Not Hispanic ____Hispanic ____Cuban Hispanic ____Mexican Origin ____Unknown
Living Arrangement:____Home ____W/Relative ____W/Friend ____Houseless ____Other
Pregnant: _____ Yes ____No Tobacco Use:____Yes ____No Highest School Grade Completed ____

Emergency Contact

Emergency Contact:_____ Relationship: _____Phone#_____
Resides in _____(City) _____ (State)

Employment Information

Employer:_____Occupation:_____
Address:_____ City/Zip:_____
Phone Number:_____
____Full Time ____Part Time ____Retired ____Disabled ____Unemployed ____Self Employed
____Student ____Home Maker ____Other:_____

Marital Status

Married___ Widowed___ Divorced___ Single___ Separated___ Unknown___

Military Status & Referral Source

Served___ Serving___None___ Branch_____ | Referred by:_____

Responsible Party/Parent/Legal Guardian/Primary Care Giver

Name: _____ DOB: _____ Sex:____SSN:_____
Employer: _____ Occupation:_____ Work#_____
Address: _____City/Zip:_____ Home/cell#_____

Spouse/Significant Other Information

Name: _____ DOB: _____ Sex:____SSN:_____
Employer: _____ Occupation:_____ Work#_____
Address: _____City/Zip:_____ Home/cell#_____

Medical Information

PCP: _____ Location:_____ Phone#_____
Dentist: _____ Location:_____ Phone#_____
Psychiatrist (if applicable):_____ Phone #_____
Medical Diagnosis (if applicable:_____ Date of Diagnosis:_____
List Medications:_____
_____

Insurance Information

Health Insurance Plan:_____ Policy Holder:_____
ID#_____
EAP/Secondary Insurance Plan:_____ Policy Holder:_____
ID#_____ Authorization/Certification#:_____
Self Pay _____

Income/Financial Information

Gross Monthly Household Income: $_____ Number of Dependents:_____
Source of Income: ____Wage/Salary ____ Public Assistance ____ SI/Disability ____ Retirement
Other_____

I authorize New Priorities Family Services to provide information to my insurance carrier, including diagnosis, services rendered, and progress, as needed to process my insurance claim. I also authorize payment of mental health therapy/counseling benefits to New Priorities Family Services for services provided.

Client Signature _____ Date_____

Intake Information

Date: _____ Name: _____ DOB: _____ Age: _____

Main concern you want to talk about: _____

Describe your strengths in your own words: _____

_____

Your goal for counseling and what you're ready to do to reach it: _____

_____

Anything else you'd like to share that feels important: _____

_____

Problem Checklist

Never	Sometimes/Often		Never	Sometimes/Often	
____	____	Loss of Appetite	____	____	Eat too much
____	____	Poor sleep/sleep too much	____	____	Nightmares
____	____	Not performing in school or work	____	____	Not doing household chores
____	____	Work too hard/over ambitious	____	____	Can't make friends
____	____	Feel people are down on me	____	____	Shy with people
____	____	Unable to have a good time	____	____	Feel rejected
____	____	Communication problems/spouse	____	____	Communication problems/child
____	____	Sex problems	____	____	Financial problems
____	____	Feel depressed	____	____	Feel inferior to others
____	____	Emotions/feelings are numb	____	____	Lack self-confidence
____	____	Worry a lot	____	____	Can't make decisions
____	____	Don't enjoy any activities	____	____	Forgetfulness
____	____	Lack of goals	____	____	Unable to cope
____	____	Afraid of being on own	____	____	Suicidal thoughts
____	____	Feel tense/anxious	____	____	Feel angry/physically
____	____	Unable to be intimate	____	____	Crying spells
____	____	Other:_____			

Substance Use Services Intake

What brings you in today? Please explain: _____

_____

Are you here by choice? Please explain: _____

_____

What is your drug of choice: _____

How old were you at first time of use?_____ How much/often do you us?_____

Last day of use?_____

Do you think you will benefit from treatment? Please explain? _____

_____

Therapy Attendance Policy

In order for us to ensure the best possible results from therapy, you must actively participate in the program developed for you by attending all scheduled sessions.

Appointment Cancellation

We realize there may be circumstances that require you to change your scheduled appointment. When these situations occur, please notify your therapist 24 hours prior to your scheduled appointment change so we may accommodate others waiting for therapy and to avoid cancellation fee.

Appointment No Show

Our Therapists have set aside a specific time to provide your therapy. When you do not call to cancel or do not show for your appointment, this is time the therapist could be providing therapy to someone else. We realize that emergencies do occur, please call right away to make arrangements with your therapist.

Repeated Cancellations or No Shows

Cancellations or no shows will be documented in your chart. After 3 cancellations and/or 2 no shows we will conclude your services. This shows the therapist, agency, and insurance company this may not be the time for you to engage in therapy.

Tobacco/Smoke Free Property

We are committed to keeping a safe and healthy space for employees, clients, volunteers, and visitors by removing exposure to tobacco smoke, vaping emissions, and similar products on our property and during work activities. This policy covers everyone on-site, all organizational spaces and vehicles, and any off-site work done for the organization.

New Priorities Family Services is a tobacco-free and smoke-free workplace. Use of tobacco products or smoking devices are not allowed at any time inside buildings, near entrances or air systems, in parking areas, in company vehicles, or during work hours when representing the organization. Please use designated smoking areas that have been established for each location.

Tobacco products include cigarettes, cigars, pipes, smokeless tobacco, and hookah. Smoking devices and electronic systems include e-cigarettes, vape pens, electronic cigars or pipes, and any device used to inhale vaporized nicotine or other substances.

Marijuana or cannabis smoking or vaping is also not allowed on our property, regardless of prescription status, unless the law requires otherwise. Employees who do not follow this policy may face disciplinary steps. Visitors or clients may be asked to stop or leave the area.

Breaks: This policy does not provide extra break time for tobacco use. Leaving the property is only allowed during approved breaks.

I have read the attendance policy and tobacco/smoke free property policy. I acknowledge my understanding of active participation for scheduled therapy sessions.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date_____

Declaration for Treatment

Advanced Directive

A written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.

Declaration for Mental Health Treatment

A Declaration for Mental Health Treatment (DMHT) is a legally binding document—often called a psychiatric advance directive—that allows individuals to outline their preferences for mental health care, including treatments, medications, and facility preferences, before a crisis occurs. It is used only when a court or doctors deem the person incapable of making their own decisions.

Please INITIAL on the following to indicate a **Yes** or **No** answer

Do you have an Advance Directive?

Do you have a Declaration for Mental Health Treatment? ____ ____

Would you like help completing a Declaration for Mental Health Treatment? ____ ____

Would you like an info packet about Declaration for Mental Health Treatment? ____ ____

Are you a registered voter? ____ ____

Would you like a voter's registration card? ____ ____

____ ____

I have read and understand the declaration for treatment questions stated above.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date_____

Visit these websites for more information on Declaration of Mental Health Directive and Advanced Directive

www.Oregon.gov/oha/amh/pages/services/planning.aspx
www.Oregon.gov/DCBS/insurance/shiba/Documents/advancedirectiveform.pdf

Behavioral Health Services Agreement

Payment/Co-Payment/Coinsurance

Payment for services is expected at time of service, but payment plans can be arranged with the billing department. Self-pay fees and/or co-pay assistance may be available depending on your income and circumstances. In the event you may need assistance please discuss your circumstances with your counselor. _____(Initial)

Payment Options

Currently we can accept cash, checks, Visa/MC debit cards, and HSA cards. Be aware that there will be a charge of $50.00 for returned checks due to insufficient funds. If you have any questions, please check with us prior to your session.

Insurance

As a courtesy, we submit an insurance claim to your insurance company for reimbursement. Please make sure you understand your Insurance Policy and the services it provides and covers. Some Insurance companies/plans require pre-authorization for services, you are responsible for contacting your insurance to ensure services will be covered and provide us with any necessary authorization/certification numbers, expiration dates, or visit limits given to you by your insurance.

Reprocessing Of Claims

Failure to notify NPFS of any changes to your billing information and/or insurance coverage within 10 days will result in an additional reprocessing fee of $50.00 but not limited to based on the lapse in notification of changes to NPFS.

You will be financially responsible should your insurance not reimburse any claims for services rendered at NPFS. Additional fees will apply if payment to NPFS is not made and balance is transfered to our third party collections agency. Urinalysis collection is not reimbursed by many payers and therefore charged at $15.00 by NPFS.

Appointments

Your designated appointment time is a commitment between you and NPFS to provide you the services needed. Both your time, and our time is valuable. Therefore, we require a 24-hour notice of cancellation. We realize that emergencies do occur. Please call our office right away to make arrangements with your therapist, or you will be charged a fee of $50.00 for No Call/No Show or late cancellation (OHP exempt).

Mental Health Service Fees	SUD Service Fees
• Initial Evaluation/Consultation $270	• Alcohol/Drug Assessment $270
• Individual Therapy (30 min.-1hr) $120-$240	• Individual Session (1-4 units) $60-$240
• Family Therapy $205-$240	• Family Therapy $145-$240
• Group Therapy $70	• Group Therapy $70
• OHP Individuals - Cost of services set by State	• UA Collection Fee $25

I have read and understand the services agreement stated above.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date _____

Grievance Policy and Procedures

NPFS staff work to resolve concerns as quickly and simply as possible.

How to File a Grievence

- Start with an open conversation with your clinician about your concerns.
- Grievance will be put in writing and placed in individual's file. (Grievance forms can be found in the reception area or obtained upon request)
- If the concern is not resolved, submit the grievance to the NPFS Director or Supervisor. They will respond within 72 hours.
- All grievances are reviewed and completed within 30 days. NPFS leadership will document each step of the process and any actions taken.

Expedited Grievances

If waiting could cause harm, you or your guardian may request a faster review. The Program Director will respond in writing within 48 hours, including information about how to appeal.

Grievance Appeals

You or your guardian may appeal any decision within ten working days of NPFS's response or service denial. Appeals are submitted to the State of Oregon Health Authority, which will respond within ten working days. If you are not satisfied, a second written appeal may be filed within ten days to the Division Director.

If you feel your grievance is not being handled, you may contact:
State of Oregon Health Authority – 503-945-5772
Disability Rights Oregon – 503-243-2081
Pacific Source Grievance and Appeals – 1-888-863-3637
The Governor's Advocacy Office – 503-945-6904

I have read and understand the grievance policy and procedures stated above.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date _____

Individual Rights

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

(a) Choose from services and supports that are consistent with the assessment and service plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for the greatest degree of independence;

(b) Be treated with dignity and respect;

(c) Participate in the development of a written service plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written service plan;

(d) Have all services explained, including expected outcomes and possible risks;

(e) Confidentiality and the right to consent to disclosure in accordance with ORS 107.154 (Authority of parent when other parent granted sole custody of child), 179.505 (Disclosure of written accounts by health care services provider), 179.507 (Enforcement of ORS 179.495 and 179.505), 192.515 (Definitions for ORS 192.515 and 192.517), 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 (Disclosure of written accounts by health care services provider);

(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 (Right to care for certain sexually transmitted infections without parental consent) through 109.697 (Right to contract for dwelling unit and utilities without parental consent) if the individual is a child, as defined by these rules;

(t) Exercise all rights set forth in ORS 426.385 (Rights of committed persons) if the individual is committed to the Authority; and

(u) Exercise all rights described in this rule without any form of reprisal or punishment.

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

(a) Information given to the individual shall be in written form or, upon request, in an alternative format or language appropriate to the individual's need;

(b) The rights and how to exercise them shall be explained to the individual, and if applicable the guardian; and

(c) Individual rights shall be posted in writing in a common area.

I have received a copy of this document and understand the information provided in this document.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date _____

Consent to Treatment

I,_____ / _____
(First, Last Name) (Date of Birth)

am voluntarily requesting services with New Priorities Family Services (NPFS). I understand and agree that NPFS may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to and/or consult with Director, along with other health care providers, including other providers within NPFS, for my care and treatment.
- Determine my eligibility for insurance coverage, submit bills, claims and other related information to my insurance company or others who may be responsible to pay for some or all my health care.
- I am freely choosing to enter treatment, and I understand that I may discontinue treatment at any time.

I give my authorization and consent to receive outpatient diagnostic and treatment services from New Priorities Family Services and _____.
(Assigned Counselor)

- I have been given information regarding my rights and responsibilities as a client.
- I have been given information regarding the limits of confidentiality of my records.
- I have been given information regarding the cost of the services from NPFS and I agree to pay all charges not paid by my insurance or any other payer source. If legal proceedings are required to collect this account, I agree to pay all collection fees.
- I understand that I may address any concerns or grievances with my therapist or any other representative of NPFS.
- I understand that I may also contact the licensing board, which regulates my therapist's professional practice.

Client Signature _____ Date _____

Witness Signature _____ Date _____

Informed Consent for AI Assisted Clinical Documentation

Our clinic utilizes artificial intelligence (AI)–assisted technology to support clinicians in drafting clinical documentation, such as progress notes, treatment summaries, and related administrative documents. These tools are used to improve efficiency and accuracy in recordkeeping.

AI technology may assist by:

- Transcribing session content (if applicable)
- Drafting progress notes based on clinician input
- Formatting documentation
- Summarizing clinical information

AI tools are used only as a support tool. All documentation is reviewed, edited, and finalized by your clinician. AI does not make clinical decisions, diagnoses, or treatment recommendations.

Privacy and Confidentiality

We are committed to protecting your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws.

- AI tools used by this clinic are HIPAA-compliant or covered under a Business Associate Agreement (BAA), when required.
- Information processed through AI tools is safeguarded using appropriate administrative, technical, and physical security measures.
- Your information will not be used to train public AI systems.

Risks

While safeguards are in place, potential risks may include:

- Data security risks inherent in electronic systems
- Inaccuracies in AI-generated drafts (which are reviewed and corrected by your clinician)

Benefits

Potential benefits include:

- More timely and thorough documentation
- Improved accuracy and consistency in records
- Increased clinician focus during sessions

Voluntary Consent

Your consent to the use of AI-assisted documentation is voluntary. You may decline or withdraw consent at any time without affecting your services. If you decline, documentation will be completed without AI assistance.

I have read and understand the information above regarding the use of AI-assisted clinical documentation. I have had the opportunity to ask questions.

- ○ I voluntarily consent to the use of AI technology as described.
- ○ I decline to the use of AI technology as described.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date _____

Informed Consent for Telehealth Therapy

Telehealth therapy uses electronic communication like video, phone, email, or text to offer therapy from a distance. This can include psychotherapy, consultation, assessment, and education through secure platforms.

Confidentiality

Laws that protect your privacy still apply. Sessions take place on a secure, HIPAA-compliant platform. The same limits to privacy apply, such as concerns about safety, abuse, neglect, or court orders.

Risks

Even with strong protections, technology can fail or be accessed without permission. Internet problems or platform issues may interrupt a session. Some concerns may need in-person care or emergency support.

Benefits of Telehealth

Telehealth offers easier access to care from home or while traveling, more flexible scheduling, and continued support during illness or emergencies.

Client Responsibilities

You must be physically in Oregon during sessions, as your therapist is licensed in that state. If you plan to travel, let your therapist know ahead of time. Make sure you have a private, quiet space without interruptions. Do not record sessions without written permission. Share your location at the start of each session in case emergency help is needed.

Emergency Situations

Telehealth is not for emergencies. In a crisis, call 911 or go to an emergency room. You can also reach the Suicide & Crisis Lifeline at 988.

Technology Requirements

- A steady internet connection.
- A device with a camera and microphone.
- The ability to use secure video platforms such as Zoom for Healthcare, Doxy.me, or Google Meet.

Fees and Insurance

Telehealth fees are the same as in-person sessions unless stated otherwise. Check with your insurance provider about coverage.

I have read and understand the information above about telehealth services.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date _____

Notice of Privacy Practices Acknowledgment & Consent

By law, all information shared during psychotherapy is kept private and will not be released without your written permission, except in the situations listed below:

- Suspected child abuse
- Immediate danger to yourself or others
- Your request for my court testimony
- Consultation with licensed professionals
- Responding to a claim made against the provider
- If you are a minor, your legal guardian may have access to your information

I understand that New Priorities Family Services may use and share my health information. This may include written, electronic, or verbal details about my health history, symptoms, exams, test results, treatments, diagnosis, procedures, prescriptions, and similar information.

I understand that I may review a written Notice of Privacy Practices, which explains how my information may be used and shared, and outlines my rights. I understand this Notice may change, and I may request an updated version at any time. A current copy will always be available in the waiting area.

I understand I may ask for limits on how my information is used or shared, though New Priorities Family Services is not required by law to agree.

I confirm that I have read and understand the information above and have received a copy of the Notice of Privacy Practices.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date _____

FOR OFFICE USE

I attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:
Emergency situation prevented us from obtaining acknowledgement _____
Communication barriers prevented us from obtaining acknowledgment _____
Individual refused to sign _____
Other (please specify)_____

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Notice of Privacy Practices

What are your privacy rights?

You can ask us to limit how we use or share your information. Your request must be in writing, and we will agree when the law allows. You can also ask us to contact you in a specific way or place, and we will follow any realistic request. You may view or get copies of your records. Requests must be in writing, and there may be a fee. Contact us for the form. You may also ask to change information in your medical or billing records. This must be in writing, and in some cases we may not be able to approve the change. You can ask for a list of when we shared your health information after April 14, 2003. This list does not include information shared for treatment, payment, or health care operations, or when you gave permission. You may take back your written permission at any time by asking in writing. Information already shared cannot be taken back.

What is protected?

Protected Health Information (PHI) includes any medical information with your name on it. Your records may be stored on paper or in a computer. They describe your treatment, tests, and health care choices. By law, we must keep this information private except in certain situations. All Deschutes County Health Services employees and volunteers must follow these rules.
When we need your written permission:
This includes sharing certain information such as mental health, alcohol and drug treatment, HIV/AIDS testing or treatment, and genetic testing.

How we may share your PHI:

For medical treatment, payment, your care, appointment reminders, and to tell you about services. We may share information with our business partners, labs, pharmacies, and interpreters.

Special situations:

We may talk with people who help with your care; for workers' compensation; to schedule interpreters; in the event of disease; to report births or deaths; during a health emergency; or when there is a serious threat to your safety or the safety of others.

Legal purposes:

We may share information for court requests, to report suspected abuse or neglect, for investigations or audits, to jails or prisons, or for national security.

Privacy complaints:

If you have concerns about how we use or disclose your information, you may file a complaint. You will not be punished, and your care will not be affected. To file a privacy complaint, contact:

NPFS Program Director (541) 923-2654 Fax (541) 548-8099
1655 SW Highland Ave Suite 3, Redmond, OR 97756

Deschutes County Risk Manager (541) 330-4631 Fax (541) 617-4704
1300 NW Wall St Suite 200, Bend, OR 97701

Secretary of the Department of Health & Human Services Region 10 HHS
Voice (206) 615-2290 TDD (206) 615-2296 Fax (206) 615-2297

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Infectious Disease Risk Assessment

Client Printed Name _____ Date of Birth _____

PLEASE **INITIAL** EACH ANSWER. ALL QUESTIONS ARE REQUIRED TO BE COMPLETED.

In the last year:	Yes	No	Don't Know
1. Have you seen a healthcare provider in the past three months?	_____	_____	_____
2. Do you live on the street or in a shelter?	_____	_____	_____
3. Have you been in jail, prison, or juvenile detention?	_____	_____	_____
4. Have you ever lived in a long-term care facility (such as a nursing home or mental health hospital)?	_____	_____	_____

5. Where were you born? _____

6. How long have you lived in the United States?

_____ Years _____ Months

In the last 30 days:

7. Have you had any of the following for more than two days?

Check all that apply:

- ☐ Fever
- ☐ Night sweats that required changing clothes or sheets
- ☐ Productive cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Lumps or swollen glands in the neck or armpit
- ☐ Unplanned weight loss
- ☐ Diarrhea lasting more than a week
- ☐ Women: Missed your last two periods

	Yes	No	Don't Know
8. Any type of vaginal, rectal, or oral contact without protection (condoms or other barrier) with or without your consent?	_____	_____	_____
9. Have you had sex or shared needles to inject drugs with a person who has AIDS or was tested positive on the antibody test for AIDS/HIV disease?	_____	_____	_____

If you answered "NO" to all the questions, you are not at risk for AIDS.
If you answered "YES" or "DON'T KNOW" to any question, you may be at risk for AIDS.

The following questions are asked to help with treatment planning. It is not required that you answer them to participate in the assessment and/or treatment.

	Yes	No
1. Have you ever had a blood test for HIV antibody?	_____	_____
2. If "NO", would you like a blood test?	_____	_____
3. If "YES", have you been tested in the last 6 months?	_____	_____
4. How would you judge your own risk for being infected with HIV (the AIDS virus)?	_____	_____

PLEASE **INITIAL** WHAT DESCRIBES YOUR AIDS/HIV RISK.

I think I am high risk. _____

I think I am low risk _____

I think I am at no risk. _____

I am not sure what my risk is. _____

You may contact your local health department to schedule an appointment to get tested for HIV.

Deschutes County Health Department 541-322-7400 (Bend)
Deschutes County Health Department 541-617-4775 (Redmond)
Jefferson County Health Department 541-475-4456 (Madras)
Crook County Health Department 541-447-5165 (Prineville)

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date_____

NPFS Successful Treatment Completion

NPFS outpatient substance abuse program has the goal of providing you with a treatment experience that is based on your needs. An assessment and treatment service plan will be developed between you and your counselor. If you have a probation officer your treatment plan at NPFS will align with your case plan. Completion of 100% of your measurable goals outlined in your service plan is one of the main factors in successfully completing treatment. You will be expected to remain free of substances during treatment.

In addition the following criteria must be met (your personal situations will always be considered by your primary counselor in making determinations regarding the successful completion of your treatment).

Individual must attend 100% of all scheduled treatment appointments (such as groups, recovery mentor, and individual counselor.

Abstinence must be documented through observed drug testing throughout our treatment program, minimum of twice each month. DUII clients will have a minimum of 90 consecutive days substance free to meet state requirements. This will be verified by urinalysis tests.

Completion of a written comprehensive relapse prevention plan that has been reviewed and approved by your primary counselor. Plan will be established by 3rd session and gone over at last session with primary counselor.

Active participation in groups and individual appointments.100% of service plan goals will be completed before satisfactory treatment goals will have been met.

Confirmation by your referring agent (probation officer, DHS worker, court etc.) that you have demonstrated prosocial behaviors such as engagement in school, other structured activities, employment, and no recent supervision violations etc.

I have read and understand how my participation will result in successful treatment completion.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date_____

Client Dress Code

To support structure, dignity, and shared community standards, NPFS asks all clients in the SUD program to follow a casual, equitable dress code that supports physical and emotional safety.

1. Comfortable, Everyday Clothing
Clients are welcome to wear relaxed clothing suitable for daily activities and group involvement. Attire is expected to reflect a respectful, recovery-focused setting.

2. Clothing Coverage
Clothing must fully cover the chest, stomach, buttocks, and groin. Shorts and skirts need to reach at least mid-thigh. See-through items are not allowed unless paired with opaque layers. Sleepwear is only for bedrooms or approved sleeping areas.

3. Footwear
Shoes, slippers, or sandals are required in all shared spaces for safety.

4. Items Not Allowed
Clothing may not display gang-related symbols, violent or sexual imagery, drug-related content, or discriminatory messages.

5. Gender-Neutral Guidelines
All expectations apply to everyone. Clients may dress in ways that reflect their identity while staying within these guidelines.

6. Respect for Others
Clients are asked to consider peers' trauma histories, cultural backgrounds, and personal boundaries. Dressing modestly helps keep the space safe and welcoming.

7. Supportive Approach
If clothing does not meet expectations, staff will address it privately and respectfully to support understanding and preserve dignity.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date_____

NPFS Urinalysis

Intensive Outpatient Day Treatment

Urinalysis during breaks is based on the judgment of the facilitator and technician. Reasonable scheduling changes may be allowed by the office manager or urinalysis technician. Testing times may change at any point, and clients will be informed as soon as possible. If a holiday falls on a testing day, urinalysis will take place the next business day.
Urinalysis is held every Monday, Wednesday, and Friday during the times listed below.

Monday	Wednesday	Friday
8:00am-9:00am	8:00am-9:00am	8:00am-9:00am
12:00pm-1:00pm	12:00pm-1:00pm	12:00pm-1:00pm

Legal Status (DUII)

Clients in legal status programs, including DUII, will complete urinalysis on a randomized color schedule Monday through Friday. Your assigned color will be given at your assessment. Daily colors can be checked on NPFS' website or by calling the office. Extra testing days may be added based on your treatment plan. At least 90 days of testing is required, with more time added if tests are missed or positive. Testing is only available during the listed times.

Mon.	Tues.	Wed.	Thur.	Fri.
8:00am-5:30pm	8:00am-5:30pm	8:00am-5:30pm	8:00am-5:30pm	8:00am-1:00pm

If you cannot make these days or missed a urinalysis, please call us. Urinalysis requires staying free from all drug and alcohol use except for prescribed medications. Please bring copies of any current or new prescriptions before testing. Urinalysis will be completed at the time of your assessment. NPFS collects your sample, and a third-party lab processes and tests it, which may cause delays. **Billing from the lab is separate from NPFS services.**

NPFS

NEW PRIORITIES FAMILY SERVICES

With hope, with change, brings new life.

1655 SW Highland Ave Suite 3, Redmond, OR, 97756 | (P)541.923.2654 | (F)541.548.8099

Release of Infomation Consent

Patient Name:_____ Patient DOB: _____

Records Authorized by Client

With this document, I authorize New Priorities Family Services to receive and disclose the following protected healthcare information: Please INITIAL on the line of authorized records.

◯_____ Identity, dates, diagnoses, prognoses, recommendations, treatment rendered, assessments, locations, progress notes, treatment status, dialogue with recipient, treatment summary, and treatment coordination.

◯_____ Mental Health Treatment, including Psychiatric/Medication History (past & present)

◯_____ Medical Services, including Medication History and Prior Hospitalizations (past & present)

◯_____ Employment (past and present)

◯_____ Family (past and present)

◯_____ Education (past and present)

◯_____ Legal Involvement (past and present)

◯_____ Alcohol and Drug Treatment (past and present)

◯_____ Other:_____

Organization or Individual Authorized by Client

The following individual or organization is authorized to receive or disclose this patient's protected healthcare information with New Priorities Family Services.

Organization:_____

Name/Title and/or Individual:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

Purpose of Authorization

The patient agrees to this authorization for the following purpose(s):

_____ Client Request _____ Court/Litigation _____ Counseling/Therapeutic Value

_____ Other, specify:_____

I understand that my mental health and/or alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol/Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 C.F.R. Parts 160 & 164. These records cannot be disclosed without my written consent unless otherwise permitted by these regulations. This Authorization includes any references to diagnosis, testing, and/or treatment for communicable diseases, including sexually transmitted infections, mental health services, and alcohol/drug services.

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in reliance on it, including provision of healthcare services requiring subsequent disclosure for payment. Unauthorized re-disclosure by the recipient is prohibited but may pose a potential risk. I understand that I do not have to sign this authorization to receive healthcare benefits, except for services required to create an assessment or report for disclosure to the recipient identified in this authorization. This authorization expires automatically one year from the date of my signature or upon written revocation.

Client Signature _____ Date_____

Witness Signature _____ Date_____

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ROI for Nepenthe Laboratory

Patient Name:_____ Patient DOB: _____

Records Authorized by Client

With this document, I authorize New Priorities Family Services to receive and disclose the following protected healthcare information: Please INITIAL on the line of authorized records.

- ◯ _____ Identity, dates, diagnoses, locations, test results
- ◯ _____ Medical Services, including Medication History and Prior Hospitalizations (past and present)
- ◯ _____ Financial/Insurance Information
- ◯ _____ Urinalysis Information

Organization or Individual Authorized by Client

The following individual or organization is authorized to receive or disclose this patient's protected healthcare information with New Priorities Family Services.

Organization:_____

Name/Title and/or Individual:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

Purpose of Authorization

The patient agrees to this authorization for the following purpose(s):

_____ Client Request _____ Court/Litigation _____ Counseling/Therapeutic Value

_____ Other, specify:_____

I understand that my mental health and/or alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol/Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 C.F.R. Parts 160 & 164. These records cannot be disclosed without my written consent unless otherwise permitted by these regulations. This Authorization includes any references to diagnosis, testing, and/or treatment for communicable diseases, including sexually transmitted infections, mental health services, and alcohol/drug services.

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Client Signature _____ Date_____

Witness Signature _____ Date_____

ADSS Referral Acknowledgment

Clients seeking treatment, due to a DUII are required to be evaluated by a Drug & Alcohol Evaluation Service (ADSS). After the evaluation, a referral will be sent to your treatment facility. The treatment facility will then send status reports back to ADSS to inform them on the client's treatment status.

NPFS Staff has received ADSS Referral. Yes_____ No_____

Are you here because of a DUII? Yes_____ No_____

Who referred you to New Priorities Family Services (NPFS)?_____

Have you been a client at NPFS in the past? Yes_____ No_____ if yes, when?_____

Have you been mandated to be evaluated by an ADSS?_____

Have you been evaluated by JC Evaluations? Yes____ No____

If yes, what was the date of your evaluation?___/___/_____ (mm/dd/yyyy)

Have you been evaluated by another ADSS in another county? Yes____ No____ if yes, who?

_____

Has ADSS referred you to, or have you been seen by another treatment facility, prior to NPFS
Yes____ No____ if yes, who?_____

I_____, understand that if I enter treatment at NPFS
Client Name
because of a DUII, but have not been to ADSS, or NPFS does not receive an evaluation from ADSS, my treatment at NPFS MAY NOT, OR WILL NOT count towards satisfying my DUII requirements, and NPFS will determine my level of treatment at time of assessment at NPFS.

I have read and understand the ADSS referral requirements.

Client Printed Name _____ Date of Birth _____

Client Signature _____ Date_____