



Phoenix Wellness Center Application For Services

145 North Coast Hwy Unit B
Newport, OR, 97365

INSTRUCTIONS: Please take time to fill out each line with a complete answer. **This information is confidential, in compliance with federal and state regulations, it is used to help staff serve you.**

Date: _____

Print Legal Name:

FIRST MIDDLE LAST

Birth Name (if different from above): _____

DOB: _____ Age: _____ Gender: _____

Mailing Address: _____
City State Zip

Contact Preference: Cell Phone Home Phone Alternate Phone

Cell Phone: _____ Cell Phone Provider: _____

Home Phone: _____ Alternate Phone: _____

Email: _____

Tribal Affiliation: _____ Enrolled: No Yes Roll #: _____

Who referred you to this program?

- Self Family/Friend Probation/Parole State or Circuit Court Drug/HOPE court
 DHS/ICW Employer Medical Provider Other:

Insurance Company: _____

Insurance ID #: _____

Date enrolled with the above Insurance Company: _____

CONSENT TO TREAT

I give my consent to participate in the services provided by Phoenix Wellness Center. I have been informed that I have the right to be referred for mental health services. I understand that by signing below I am giving Phoenix staff consent to assist me with accessing addiction services.

Signature of Client, Personal Representative or Guardian

Date

Staff Signature

Date



Phoenix Wellness Center LLC Tobacco Questionnaire



Name: _____ Date: _____

The following questions pertain to non-ceremonial use of tobacco only.

1. Are you exposed to second hand smoke? Yes No

If so, describe: _____

2. Do you use tobacco products? Yes No

If so, how much do you do the following a day: _____

Smoke:

Chew:

Vaping:

3. Is this usage different from your usage one year ago? Yes No

If yes, what is different? _____

4. Have you ever thought of quitting? Yes No

If yes, when do you see yourself quitting? _____

5. What kind of help/support do you feel would be helpful for you in quitting?

↓ Below Staff Use Only ↓

Referral Made: Yes No Deferred

Describe referral: _____

Signature of Client, Personal Representative or Guardian

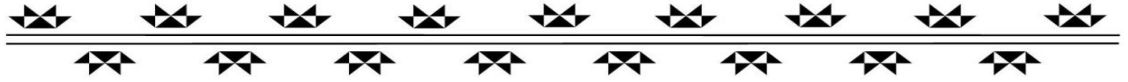
Date

Staff Witness Signature

Date



Phoenix Wellness Center LLC Health Questionnaire



Client Name: _____

Date: _____

In order to help you find out if you are at increased risk for HIV and/or Hepatitis, we ask that you answer the following questions honestly. This information will be kept strictly confidential and will not be released to anyone without your written permission. If we find that you are at increased risk, we will provide you with information which will hopefully help you make changes to avoid becoming infected, spread infection to others, and get medical care which may reduce symptoms.

1. Have you seen a doctor or other health care provider in the past three months? Yes No Unsure

2. Do you, or have you, lived on the street or in a shelter? Yes No Unsure

3. Have you ever been in jail, prison, or juvenile detention? Yes No Unsure

4. Have you ever been in a long-term care facility (hospital, nursing home)? Yes No Unsure

5. Where were you born: _____

6. How long have you been in the US: _____ years, _____ months

7. Within the last 30 days, have you had any of the following symptoms lasting more than two weeks?

- | | | |
|--|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Productive cough | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Shortness of breath? | <input type="checkbox"/> Losing weight without meaning to? | <input type="checkbox"/> Diarrhea (runs) lasting more than a week? |
| <input type="checkbox"/> Lumps or swollen glands in the neck or armpits? | <input type="checkbox"/> Drenching night sweats causing you to change clothes or sheets? | <i>WOMEN: Have you missed your last two periods?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No |

8. Have you ever been tested for tuberculosis (TB)? Yes No Unsure

If so, when: _____

9. Have you ever been told you have TB? Yes No Unsure

10. Has anybody you know lived with or been diagnosed with TB in the past year? Yes No Unsure

11. Have you ever had a positive skin test for TB? (A test where they gave you a shot in your forearm and a few days later a hard bump appeared.) Yes No Unsure

12. Have you ever been treated for TB? Yes No Unsure

13. Have you ever been tested for Hepatitis? Yes No Unsure

When: _____

14. Have you ever been told you have Hepatitis? Yes No Unsure

15. Have you or are you receiving medical treatment for Hepatitis? Yes No Unsure

16. Have you ever had a blood test for HIV antibody? Yes No Unsure

17. Have you or are you receiving medical treatment for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
18. Do you use needles to shoot drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
19. Have you shared needles or syringes, even once, to inject drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
20. Do you use stimulant (e.g cocaine/methamphetamines)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
21. Have you inhaled (snorted) drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
22. Have you shared straws, even once, to inhale drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
23. Have you had a tattoo prior to 1990?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
24. In the last six months have you or anyone you have had sex with had any sexually transmitted diseases (STD's), like syphilis, gonorrhoea, herpes, Chlamydia, nongonococcal urethritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
25. Have you had a blood transfusion prior to 1987?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
26. Have you had unprotected sex with someone who has the blood disease hemophilia?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
27. Have you had unprotected sex with someone who injects drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
28. Have you had unprotected sex with a man who has sex with other men?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
29. Have you had sex in exchange for money or drugs, in order to survive?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
30. Have you had sex with more than one person in the past six months? Any type of vaginal, rectal, or oral contact without protection (condom or other barrier) with or without your consent?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
31. Have you had sex or shared needles to inject drugs with a person who has AIDS or who tested positive on the antibody test for AIDS/HIV disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
32. Have you had sex or shared needles to inject drugs with a person who has Hepatitis C?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

- If you answered no to all the questions, you are not at increased risk for communicable diseases.
- If you answered yes or don't know to any questions you could be at risk for a communicable disease.

Have you received a full blood test within the last six months? Yes No

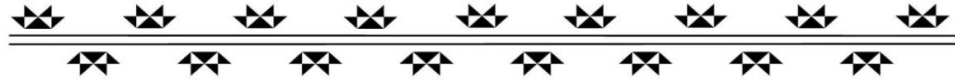
If no, would you like a blood test? Yes No

How would you judge your own risk for being infected with a communicable disease?

- I know I am infected
 I think I am at high risk
 I think I am at low risk
 I think I am at no risk
 I am not sure what my risk is



Phoenix Wellness Center LLC Telehealth Consent Form



DEFINITION OF SERVICES: I hereby consent to engage in telehealth/telemedicine with [Phoenix Wellness Center](#). Telehealth/telemedicine is a form of behavioral health and psychiatric service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I understand that telehealth/telemedicine involves the communication of my medical/mental health information, both orally and/or visually. Telehealth/telemedicine has the same purpose or intention as psychotherapy and psychiatric treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to telehealth/telemedicine:

CLIENTS RIGHTS AND RESPONSIBILITIES:

- I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that protect the confidentiality of my medical information also apply to telehealth/telemedicine. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with Phoenix Wellness Center.
- I understand that there are risks and consequences of participating in telehealth/telemedicine, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my behavioral health/ medical information could be accessed by unauthorized persons.
- There is a risk that services could be disrupted or distorted by unforeseen technical problems.
- In addition, I understand that telehealth/telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be asked to attend sessions at the agency.
- I understand that I may benefit from telehealth/telemedicine, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
- If I am experiencing a crisis, I can contact Lincoln County Crisis line at 1-888-232-7192. In an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.
- I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in Telehealth/telemedicine. I am responsible for providing the necessary computer, tablet or phone and internet access for my telehealth/telemedicine sessions, and for arranging a location with privacy that is free from distractions or intrusions for my session. It is the responsibility of the treatment provider to do the same on their end.
- I understand that dissemination of any personally identifiable images or information from the telehealth/telemedicine interaction to researchers or other entities shall not occur without my written consent. This will be reviewed bi-annually

Signature of Client, Personal Representative or Guardian

Date

Oregon Voter Registration Card



SEL 500 rev 11/19

you may use this form to

- register to vote
- update your information

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.

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.

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

Only registered voters are eligible to sign petitions.

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.

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

-or-

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

-or-

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

acceptable identification

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

qualifications

- Are you a citizen of the United States of America? yes no
- Are you at least 16 years of age? yes no

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

personal information *required information

last name* first* middle

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

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

phone email

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

Oregon Driver's License/ID number

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

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

x x x - x x -

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

political party

- Not a member of a party
- Constitution
- Democratic
- Independent
- Libertarian
- Pacific Green
- Progressive
- Republican
- Working Families
- Other _____

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

sign here _____ date today _____

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

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

previous registration name previous county and state

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



Secretary of State
Salem OR 97310-0722

County Elections Offices

Baker County

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

Benton County

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

Clackamas County

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

Clatsop County

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

Columbia County

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

Coos County

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

Crook County

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

Curry County

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

Deschutes County

1300 NW Wall St, Ste 202
Bend OR 97703-1960
PO Box 6005
Bend OR 97708-6005
541 388 6547

Douglas County

PO Box 10
Roseburg OR 97470-0004
541 440 4252

Gilliam County

PO Box 427
Condon OR 97823-0427
541 384 2311

Grant County

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

Harney County

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

Hood River County

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

Jackson County

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

Jefferson County

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

Josephine County

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

Klamath County

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

Lake County

513 Center St
Lakeview OR 97630-1539
541 947 6006

Lane County

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

Lincoln County

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

Linn County

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

Malheur County

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

Marion County

555 Court St Ne, Ste 2130
Salem OR 97301-3980
PO Box 14500
Salem OR 97309-5036
503 588 5041 or 800 655 5388

Morrow County

PO Box 338
Heppner OR 97836-0338
541 676 5604

Multnomah County

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

Polk County

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

Sherman County

PO Box 243
Moro OR 97039-0243
541 565 3606

Tillamook County

201 Laurel Ave
Tillamook OR 97141-2311
503 842 3402

Umatilla County

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

Union County

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

Wallowa County

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

Wasco County

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

Washington County

2925 NE Alocleck Dr, Ste 170
Hillsboro OR 97124-7523
503 846 5800

Wheeler County

PO Box 327
Fossil OR 97830-0327
541 763 2400

Yamhill County

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