



921 Country Club Road, Suite 222, Eugene, OR 97401  
Phone: 541-686-6000 Fax: 541-344-8239

**OFFICE USE**

OPAC Intake Therapist: \_\_\_\_\_ Date of Intake: \_\_\_\_\_

Service Code: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_ Start Date: \_\_\_\_\_

Photo \_\_\_\_\_ OPAC# \_\_\_\_\_

**Client Information - PLEASE PRINT**

Client Name: \_\_\_\_\_  
(First) (Middle) (Last)

Gender: M F Identifying Gender \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Address:

\_\_\_\_\_  
(Street) (Apt/Space#) (City) (State) (Zip)

Email: \_\_\_\_\_@\_\_\_\_\_.com or net

Relationship Status: Single Partner Married Separated Divorced

Current Partner's Name: \_\_\_\_\_

Children: Age \_\_\_\_\_ Gender M F Age \_\_\_\_\_ Gender M F

Age \_\_\_\_\_ Gender M F Age \_\_\_\_\_ Gender M F

Age \_\_\_\_\_ Gender M F Age \_\_\_\_\_ Gender M F

**Fees: \$65.00 for intake; \$35 each group**

Your Fee: \_\_\_\_\_

Comments:

Responsible Party: Self Other If Other: Name \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Phone: \_\_\_\_\_

Fee is subject to increase with advance notice. Each group session is scheduled for 90 minutes. Payments for group sessions are expected at the time of service unless other arrangements have been made with the OPAC Administrator. YOU ARE RESPONSIBLE TO PAY YOUR BILL IN FULL.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

My signature indicates that the above statements are true and that I agree to the above terms.



**OPAC GROUP CONFIDENTIALITY**

Confidentiality is a particularly serious issue in OPAC groups. The general rule is that what is said in group stays in group. Because confidentiality is a basis for group safety, any breach will result in immediate expulsion from the group. However, the State of Oregon requires that the therapist breach confidentiality in the following instances:

- 1) any kind of child abuse, 2) any form of elder abuse, 3) any form of abuse toward disabled persons, 4) when a person is a danger to themselves or others.

**STATEMENT OF COMMITMENT AND CONFIDENTIALITY**

(Please initial each item)

- \_\_\_ The undersigned, as the client, hereby authorizes and consents to any and all treatment as may be deemed advisable.
- \_\_\_ I agree to attend all of the sessions and to be prompt. If I have a good reason for not attending or for arriving late, I shall notify the leaders as soon as possible and accept their decision to excuse or not excuse the tardiness or absence.
- \_\_\_ I understand the importance of confidentiality in the OPAC program. I agree never to disclose to anyone outside the group the identity of or information about the other participants.
- \_\_\_ I agree not to drink alcohol or use any unlawful drug 12 hours prior to coming to group.
- \_\_\_ I agree to pay a fee of \$65 for the intake and \$35 per session for the OPAC program to be paid at the time of service or through an arrangement made with the group facilitator. Except in the instance that I have made special arrangements with the program manager.

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Client's Printed Name

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Client Signature

Date



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### OPAC CONSENT FORM

I, the undersigned, authorize CAFA to:

(Please initial each item)

\_\_\_\_\_ Counsel me and enter me into (DV, AM, or Parenting) treatment (*required*)

\_\_\_\_\_ Test and conduct assessment

\_\_\_\_\_ Use basic information (non-identifying) for research purposes

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Client's Printed Name

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Client Signature

Date

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Staff Signature

Date



### GRIEVANCE POLICY

You have the right to address problems and seek resolution to them. The therapists and staff will assist you in this process to the best of their ability. The following are the steps to take if you feel your client rights have been violated, and/or that you have dissatisfactions, complaints or problems with the services you receive. Remember that an effective mental health treatment program requires an investment in self-change, openness and an attitude of collaboration. Thus, the best place to start in dealing with your concerns regarding your client rights and/or services you receive is with the person providing those services.

1. Begin by speaking directly to the therapist or facilitator involved or the service provider who is your primary contact.
2. If satisfaction is not mutually achieved, ask to speak with the service provider’s supervisor.
3. Again, if satisfaction is not mutually achieved, you can proceed to talk with the Director.
4. If the above procedure has not redressed your concerns, you may then seek legal counsel. You may also contact the State Professional Organization of the respective provider involved or the State Attorney General’s office.

Each client shall be offered a copy of the grievance policy and procedure at the time of admission.

I have read and understand the above policy.

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Client’s Printed Name

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Client Signature

Date

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Witness Signature

Date



**Acknowledgement of Access to Mental Health Declaration**

**I acknowledge that I have been given an opportunity to complete a declaration for mental health treatment.** "Declaration for Mental Health Treatment" means a written statement of an individual's preferences concerning his or her mental health treatment. The declaration is made when the individual is able to understand and legally make decisions related to such treatment. It is honored, as clinically appropriate, in the event the individual becomes unable to make such decisions.

Copies of mental health declaration are offered at time of intake and are made accessible in CAFA's main office in the reception area.

I have been provided access to mental health declaration forms.

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Client's Printed Name

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Client Signature

Date

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Witness Signature

Date



**Privacy Policy  
Acknowledgement and Consent**

I understand that **Christian As Family Advocates** will use and disclose health information about me. I understand that my health information may include information both created and received by the agency, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that **Christians As Family Advocates** may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related health information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support the agency’s efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.

I also understand that I have the right to receive and review a written description of how **Christians As Family Advocates** will handle health information about me. This written description is known as a notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Christians As Family Advocates, and my rights regarding my health information.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that **Christians As Family Advocates** is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand that information above and that I have been offered the opportunity to have a copy of the Notice of Privacy Practices.**

Client’s Printed Name

Client Signature

Date

Staff Signature

Date



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**Release Form to Contact Partner  
(This form is required by the State of Oregon OARs)**

It is the policy of CAFA to ask that you give CAFA written permission to contact your partner, ex-partner, etc. We ask this for the following reasons:

- We may call your partner if you leave the group angry or escalated and we have reason to fear for your partner’s safety.
- CAFA has a strict policy regarding confidentiality and we do not discuss with your partner the content of your work in group or details of what you discuss. We share information with your partner only if we have doubts about your progress in the program or concerns for your partner’s safety.

I **do not** give my permission for CAFA to contact my partner.

I give my permission for CAFA to contract my partner if staff become concerned:

Partner/Victim’s Name: \_\_\_\_\_

Address:

_____	_____	_____	_____	_____
(Street)	(Apt/Space#)	(City)	(State)	(Zip)

Phone: \_\_\_\_\_

Client’s Printed Name \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Facilitator Signature \_\_\_\_\_ Date \_\_\_\_\_



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Client's Name: \_\_\_\_\_

**If there was a specific event that led to you coming to CAFA, please describe it below. If there were a series of events or circumstances, please describe the situation to the best of your ability.**

Was this violence with a partner? \_\_\_\_\_ Were the police called? \_\_\_\_\_

Who called police? \_\_\_\_\_ Were there children present? \_\_\_\_\_

Was this an isolated incident or a normal part of your relationship?

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When did it happen?

Where did the event happen?

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Who was involved?

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Were drugs and /or alcohol involved?

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What happened?