GAMBLING TREATMENT PROGRAM EVALUATION

INFORMED CONSENT AND PARTICIPATION AUTHORIZATION

Thank you for volunteering to participate in the evaluation of the gambling treatment program. Your participation is very important and your views are highly valued. **The purpose of the evaluation is to determine the effectiveness of the treatment you receive and to improve the delivery of services for future clients**. All the information that you provide will be held in the strictest confidence in accordance with the Federal Confidentiality Law of the United States Code. All reports will only include information from groups of individuals so that no one individual's comments can be identified.

This quality improvement effort is being conducted by Herbert & Louis, LLC (the evaluator) for the Addictions and Mental Health Division (AMH), Department of Human Services, Oregon under contract. AMH is allowed to ask for the information on the various forms and questionnaires for program evaluation. AMH will not receive any information that could be used to reveal your identity.

CLIENT AUTHORIZATION

I understand that my participation in this quality improvement effort and my providing information for the forms and questionnaires is strictly voluntary. Any questions that I do not wish to answer will be skipped, and I will not be penalized for not providing any part or all of the information requested. I can refuse to participate at any point in the study and will suffer no penalty and will not be denied any services.

My involvement in the quality improvement effort will consist of participating in one 5 to 15 minute written survey at enrollment and again when I complete the program. If I choose to complete the entire treatment program offered I will be contacted again at 6, and 12 months from the time I leave the program to complete a similar follow-up survey that will take 5 to 15 minutes. If I choose not to complete the treatment program offered, I will be contacted only at six months for follow-up. These surveys will include questions about my housing, employment, physical and mental health, social relationships, gambling, and satisfaction with the program. I understand that I may be telephoned to complete the follow-up surveys if the mailed survey does not reach me. I further understand that the contact persons I provide may be called in order to reach me in case I have changed my mailing address or telephone. The contact persons I provide will not be given any information regarding my participation in treatment nor in the study. They will only be informed that I am participating in a consumer study and that they were given as a contact only if we could not reach you directly by mail or phone. Time permitting, we may attempt to contact you while you are still in treatment to introduce ourselves, answer any questions you may have regarding the follow-up, and verify the contact information we have. This call will only take about 5 minutes.

I authorize ______________________ (Treatment Provider) to provide Dr. Moore with additional information that will be used to evaluate the program. This information will consist of general admission and demographic information, treatment program attendance, and discharge

Client Initials of 1st Page: ______

information including discharge status only. This is general information only that is collected on all participants in an anonymous manner and does not include any information regarding what occurs in my individual or group counseling sessions.

I understand that I can call Dr. Thomas Moore at (503) 685-6100 (email tlmoore@herblou.com) if I have any questions or concerns or I can also call Mr. Paul D. Potter, MSW MAC, Gambling Services Manager AMH, at (503) 945-9709 if I have any questions or concerns. My signature below indicates that the purposes and procedures for this study have been fully explained to me and that I consent to participate. It does not, however, obligate me to participate. I understand that I can withdraw from the follow-up at any time by informing Dr. Moore or his staff.

Name ____________________________________ Client ID ____________
(please print)

Signature _________________________________ Date ________________

Witnessed _________________________________ Date ________________

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Client Consent Withheld

The Informed Consent and Participation Authorization has been read to me and I choose to not participate in the evaluation follow-up. Please ask the counselor to put the word "Declined" in the signature line above and sign below to ensure that you are not contacted for follow-up.

Signature _________________________________ Date ________________

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☐ Copy provided to client.