

INFORMED CONSENT & PARTICIPATION AUTHORIZATION

In order for clients (gambler and family enrollees) to be followed for the longitudinal evaluation, a copy of the signed informed consent must be on file with the Evaluator. Participation in the follow-up is completely voluntary. In order to assure that clients are provided with the opportunity to participate in the follow-up evaluation, and to ensure a consistent explanation of the involvement is provided to each client, the following Informed Consent Form should be read to the client with a copy of the Form available to the client to follow along. Clients who choose to volunteer for the follow-up should sign the Form and a copy should be given to them for their personal records. A copy of the signed Form must accompany the Enrollment Record Abstracting Form if the client has consented to participate.

Some clients may choose to not volunteer for the follow-up. These individuals should be requested to sign the last part of the Form titled "Consent Withheld." **Follow-up authorization forms for clients that elect to not participate in the program evaluation should not be sent to the evaluator**, but should be maintained in the client's confidential file with a copy going to the client.

The following form is provided as an example. The informed consent authorization form that is used by your agency should be reviewed by your agency's HIPAA Compliance Officer and/or agency legal counsel.

PLEASE NOTE: In order to be reimbursed for services, agencies will be required to provide the client's name on the enrollment form. This is the same procedure that is being used to reimburse for mental health benefits through OHA/HSD. Your agency's standard consent to treat and release documentation should contain a statement regarding the necessity to collect the client's full name, the protections that are in place and specifically name Herbert & Louis, LLC as the claims processor. Herbert & Louis, LLC is a formal Business Partner by contract with HSD, Problem Gambling Services Unit for HIPAA compliance purposes.

**GAMBLING TREATMENT PROGRAM EVALUATION
INFORMED CONSENT AND PARTICIPATION AUTHORIZATION
(EXAMPLE ONLY)**

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 Health Systems Division (HSD), Oregon Health Authority under contract. HSD/OHA is allowed to ask for the information on the various forms and questionnaires for program evaluation. HSD 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 information including discharge status only. This is general information only that is collected on

Client Initials of 1st Page: _____

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 tmoore@herblou.com) if I have any questions or concerns or I can also call the State Problem Gambling Services Unit Manager, Health Systems Division, Oregon Health Authority (503) 945-5763 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 _____
(please print)

Client ID _____

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.