SAINT LOUIS COUNSELING

Basic Information and Agreement Sheet (BIAS)

IDENTIFIED PATIENT

Last Name_____ First Name_____ MI_____

Address_____ City_____ County_____ State_____ Zip_____

Home#*_____ Work#_____ Cell#_____ Email_____

Messages can be left at the following *(please check all that apply)*: ☐ Home* ☐ Work ☐ Cell ☐ Email

**Please note automated reminder calls/messages will be made to the listed Home#.*

SS#_____ DOB_____ Age_____ Education Level/ Grade Level _____

Occupation_____ Employer_____

Emergency Contact and Phone #_____ Email_____

Gender:
- ☐ Female
- ☐ Male
- ☐ Other_____
- ☐ Prefer Not to Answer

Race:
- ☐ African American
- ☐ Asian
- ☐ Bi/Multi Racial
- ☐ Hawaiian/Pacific Islander
- ☐ Hispanic/Latino
- ☐ Native American/ Alaskan Native
- ☐ White
- ☐ Other: _____
- ☐ Prefer Not to Answer

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Widow
- ☐ Separated
- ☐ Divorced
- ☐ Domestic Partnership
- ☐ Common Law
- ☐ Other _____
- ☐ Prefer Not to Answer

How did you hear about us?:
- ☑ Radio
- ☐ Print
- ☐ Social Media
- ☐ Other Online
- ☐ Doctor
- ☐ Hospital
- ☐ Friend
- ☐ Family
- ☐ School
- ☐ Other _____
- ☐ Prefer not to answer

Religion:
- ☐ Catholic
- ☐ Christian
- ☐ Jewish
- ☐ Muslim
- ☐ Buddhist
- ☐ Nonreligious
- ☐ Other _____
- ☐ Prefer not to answer

Annual Household Income:
- ☐ $0-9,999
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-$29,000
- ☐ $30,000-$49,999
- ☐ $50,000-$100,000
- ☐ $100,000+
- ☐ Prefer not to answer

Number in Household:
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8 or more

Veteran:
- ☐ Yes
- ☐ No
- ☐ Current Military
- ☐ Other _____
- ☐ Prefer not to answer

NAME OF INSURED (If different from above)

Relationship to Identified Patient_____

Last Name_____ First Name_____ MI_____

Address_____ City_____ County_____ State_____ Zip_____

Home#_____ Work#_____ Cell#_____ Email_____

SS#_____ DOB_____ Age_____

INSURANCE INFORMATION (If applicable)

Primary Insurance_____ Member ID_____

Policy #_____ Group #_____

Secondary Insurance_____ Member ID_____

Policy #_____ Group #_____

EAP INFORMATION (Please complete only if using an EAP provider plan rather than insurance)

EAP Company _____ EAP Company Phone # _____

Authorization # _____ Number of visits approved _____ Expiration Date for visits _____

RESPONSIBLE PARTY FOR MINOR CHILD Relationship to Identified Patient_____

Last Name_____First Name_____MI_____

Address_____City_____County_____State_____Zip_____

Home#_____Work#_____Cell#_____Email_____

SS#_____ DOB_____ Age_____ Gender_____

Education_____Occupation_____Employer_____

PLEASE INITIAL AND SIGN BELOW:

_____ I certify that the above information is correct.
_____ I have received a copy of my Rights and Responsibilities.
_____ I agree to obtain the necessary authorizations to receive services.
_____ I agree to pay the fee, co-payment, and deductible and understand that payment is expected at the time services are rendered. (GRANT/ EAP EXEMPT)
_____ I agree to pay the fee, co-payment, and insurance amount for non-emergency cancellations with less than a 24-hour notice. (GRANT/ EAP EXEMPT)
_____ I give permission to Saint Louis Counseling to bill my insurance company and to receive payment for services.
_____ I understand that I remain personally responsible for payment of services provided.

Signature of Patient / Legal Guardian_____ Date_____

Signature of Therapist_____ Date_____

OFFICE USE ONLY

DATE OF 1ST VISIT_____

Client has/is using: ☐ Insurance ☐ Arch EAP ☐ Other EAP ☐ Sliding Scale

☐ Grant: _____ ☐ Project Rachel ☐ Project Joseph

FEE OR CO-PAYMENT AMOUNT $_____

DEDUCTIBLE AMOUNT $_____

Signature of Staff Member_____ Date_____

9200 Watson Road, Suite G-101 | Saint Louis, MO 63126 | P: 314.544.3800 | F: 314.843.0552

Telehealth Informed Consent

Client Name:_____ Clinician:_____

Telehealth allows my therapist to diagnose, consult, treat, and educate using interactive audio-video or telephone communication. I hereby consent to participating in psychotherapy via audio-video communication (referred to as "Telehealth" below.)

I understand I have the following rights under this Agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make toward a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. My clinician and I will establish an emergency plan and protocol for contact in between sessions. This will be established before the start of treatment, and I can request a copy of these protocols in writing. Further, I understand that the dissemination of any personally identifiable images or information from Telehealth interaction to any other entities shall not occur without my written consent.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, it may be recommended that I come into the office for sessions.

Saint Louis Counseling clinicians use Zoom to conduct telehealth sessions, in addition to telephones. Clinicians do not download any client PHI (personal health information) onto their computers, phones, or tablets, and are trained and are current in HIPAA compliance. In order to use Zoom, Saint Louis Counseling must have an accurate email address for you on file. Please add it on the back of this form.

I am responsible and not my insurance company for co-payments, coinsurances, and deductibles. I agree to obtain the necessary authorizations to receive services. I agree to pay the fee, co-payment, and deductible and understand that payment is expected at the time services are rendered. I agree to pay the fee, co-payment, and insurance amount for non-emergency cancellations with less than a 24-hour notice. I give permission to Saint Louis Counseling to bill my insurance company and to receive payment for services. I understand that I remain personally responsible for payment of services provided.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to Saint Louis Counseling. My signature below indicates that I have read this Agreement and agree to its terms.

Information for Zoom or Phone Telehealth

Email for Zoom: _____

Best phone number for phone and billing purposes: _____

_____ _____

Client Signature Date

_____ _____

Clinician Signature Date

SAINT LOUIS COUNSELING

Consent to Treatment Form

Confidentiality:
I understand that the services provided to me by Saint Louis Counseling are confidential. Except under specific circumstances, information collected during interviews and sessions can only be discussed in closed supervision meetings within Saint Louis Counseling. I am aware that there are some circumstances under which Saint Louis Counseling is required or permitted by law to release information. These circumstances include instances of suspected child abuse or neglect, in situations in which there might be danger of harm to myself or others, or in response to court orders or subpoenas. I understand that in all other circumstances, however, Saint Louis Counseling will carefully maintain my privacy.

Releases:
I hereby authorize Saint Louis Counseling to release information necessary for billing, financial or chart audits, quality assurance reviews, and for collection of nonpayment of charges. This release will be valid until I am no longer receiving services at Saint Louis Counseling and my account is settled. I also understand that the release of any other information will require my written consent.

Consent to Treatment / Assessment:
I have discussed any questions with my clinician. Thus, with understanding of the above, I hereby consent to accepting assessment, treatment, and/or care from the staff of Saint Louis Counseling.

For Minor Receiving Services:
I understand that I have the right to participate in my child's treatment and to speak with my child's clinician regarding my concerns.

_____ _____

Signature of Patient / Legal Guardian **Date**

_____

Relationship to Patient

_____ _____

Signature of Staff Member **Date**

SAINT LOUIS COUNSELING

Acknowledgement of Receipt of Notice of Privacy Practices

(Effective April 14, 2003)

I hereby acknowledge that I have received a copy of the Saint Louis Counseling Notice of Privacy Practices.

_____ _____

Signature of Client or Client's Representative Date

_____

PRINT Client or Representative Name

_____

Relationship of Representative to Client

_____

☐ Client refused to sign Acknowledgement

_____

Signature of Person Witnessing Refusal

Please print and complete the new client paperwork below and bring with you at the time of your appointment. If the new client paperwork is not completed and brought with you, you will be expected to arrive 30 minutes before your scheduled appointment time to complete. Any incomplete paperwork may cause a delay in your session time or result in the need to reschedule.

NO SHOW/LATE CANCELLATION POLICY

Please note: Our agency requires a 24 hour notice if you are unable to keep your appointment. This is necessary so that we may offer that appointment time to someone else who is waiting to see our provider. Repeatedly missing appointments or failure to give proper notice will result in a missed appointment fee, ($40.00) or dismissal from services.

Signature _____ Date _____

MEDICATION POLICY

For clients who will be seeing our psychiatrist for medication management, please note:

It is your responsibility to keep your medications and prescriptions in a safe place. If medications are lost or stolen, your insurance company will not pay to replace them until they are due to be refilled. Some of the medications can be rather costly. A serious concern is if the medication falls into the wrong hands, as this could be very dangerous. If a prescription or medication is lost or stolen, your chart will be reviewed by your physician, and he/she will decide if a replacement prescription is appropriate. Please take your medication only as prescribed unless you have discussed a change with your physician.

Signature _____ Date _____

SAINT LOUIS COUNSELING

Intake Forms – Adult

PRESENTING PROBLEM

Please tell us why you are seeking services at this time.

What do you hope to accomplish from the services you receive?

SYMPTOM CHECKLIST – Please check all that apply.

Past	Present		Past	Present	
		Addictions			Hopelessness
		Aggressive behavior			Hyperactivity
		Anger			Impulsivity
		Anxiety/worry			Isolation
		Appetite changes			Lack of motivation
		Breaking the law			Learning problems
		Crying spells			Loss/death of a significant person
		Decreased energy			Marital/relationship problems
		Depression			Mood swings
		Developmental disabilities			Physical complaints
		Difficulty concentrating			School problems
		Disobedience			Self-mutilation
		Drugs/alcohol			Sexual problems
		Eating disorders			Sleep changes
		Fears			Speech/language problems
		Fighting			Stress
		Fire setting			Suicidal thoughts
		Hallucinations			Temper tantrums
		Health problems			Wets bed
		Homicidal thoughts			Other:

FAMILY AND SOCIAL INFORMATION

Please list family members and others who are living at your address.

Name	Relationship	Age

Please list any of your children who are not living at your address.

Name	Relationship	Age

Date of Present Marriage_____
Date of Separation, if applicable_____
Date of Previous Marriage_____
Date of Separation/Divorce_____
Date of Previous Marriage_____
Date of Separation/Divorce_____

Please list your family members, including biological and step family members.

Family Member	Name	Age	Marital Status	If deceased, date and cause
Parent				
Parent				
Parent				
Parent				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

FAMILY AND SOCIAL INFORMATION (CONTINUED)

How would describe your relationship with your mother?

How would you describe your relationship with your father?

Have you or any family members been physically, emotionally, or sexually abused? If yes, please describe.

Have you ever been a perpetrator of abuse? If yes, please describe.

Is spirituality/religion a part of your life? If yes, please describe.

Who are your main social supports?

EDUCATION INFORMATION

Were you ever diagnosed with a learning or conduct disorder while in school? If yes, please describe.

Were you ever bullied in school? If yes, please describe.

EMPLOYMENT INFORMATION

How long have you been employed in your present job?

Length of longest employment:

What types of jobs have you previously held?

Are you under work/financial stress? If yes, please describe.

LEGAL INFORMATION

Have you ever been arrested? If yes, please describe.

Are you currently on probation or parole? If yes, please describe.

Are you currently involved in any legal actions such as divorce, bankruptcy, or lawsuit? If yes, please describe.

Have you ever received a DWI or DUI? If yes, please describe.

SUBSTANCE ABUSE INFORMATION

Do you smoke or use tobacco? If yes, how much and how often?

How many times a week do you drink alcohol?

How many drinks do you usually consume during each occurrence?

Have you ever felt the need to cut down on your drinking?	_____Yes	_____No
Have you ever become annoyed at criticism about your drinking?	_____Yes	_____No
Do you ever feel guilty about your drinking?	_____Yes	_____No
Do you ever need a drink in the morning to get going?	_____Yes	_____No

Do you or any family members have a history of alcohol and/or drug abuse/dependency? If yes, please describe.

MEDICAL INFORMATION

Primary Care Doctor_____ Phone #_____Last Exam Date_____

Please list any current and past impairments, illnesses, surgeries, and hospitalizations.

Please list any allergies.

How frequently do you exercise?

Pre-existing Medical Conditions

Please check all that apply.

Past	Present		Past	Present	
		Hypertension			Malaise and Fatigue
		Hyperlipidemia			Joint Pain
		Diabetes			Acute Laryngopharyngitis
		Back Pain			Acute Maxillary Sinusitis
		Anxiety			Major Depressive Disorder
		Obesity			Acute Bronchitis
		Allergic Rhinitis			Asthma
		Reflux Esophagitis			Depressive Disorder
		Respiratory Problems			Nail Fungus
		Hypothyroidism			Coronary Atherosclerosis
		Visual Refractive Errors			Urinary Tract Infection
		Osteoarthritis			Head Injury
		Fibromyalgia/myositis			Falls/Falling
		Headaches			Parkinson's Disease
		Other:			

Current Medications

Name of Medication	Dosage	Frequency	Taken As Prescribed?	Date Started	Prescribing Physician	Side-Effects

Please indicate any recent changes in the child's medication (i.e. changes in dosage/frequency, changing side effects, recently discontinued medications, etc.).

BEHAVIORAL HEALTH INFORMATION

Please answer the following questions regarding your behavior health history.

Have you received counseling before?

Have you received a mental health diagnosis? If yes, please indicate.

What did you find helpful about previous counseling?

Have you ever been hospitalized? If so, please indicate date(s) and reason for hospitalization.

Do you have a history of self-injury/suicidal ideation? If yes, please indicate the most recent incident.

Have your behavioral health concerns impacted your performance at work/school, or your relationships with family/friends? If yes, please explain.

Please list any current and previous counseling and psychiatric treatment for you and/or any family members.

Individual Receiving Treatment	**Type of Treatment** (i.e., outpatient, inpatient, residential, chemical dependency, etc.)	**Service Provider**	**Dates**

STRENGTHS

Please list some of your strengths and positive qualities.

What hobbies and interests do you enjoy?

Is there anything else you would like us to know?

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact the Privacy Officer at:
314-544-3800

WHO WILL FOLLOW THIS NOTICE

This Notice describes our Agency's practices and that of:

- Any health care professional authorized to enter information into your health record.
- All departments and units of the Agency.
- Any member of a volunteer group we allow to help you while you are receiving services from the Agency.
- All employees, staff and other Agency personnel, including personnel within other agencies of the Catholic Charities' Federation with whom we may share information.
- All these programs, sites and locations will follow the terms of this Notice. In addition, these programs, sites and locations may share health information with each other for treatment, payment or agency operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive at the agency. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the Agency, whether made by Agency personnel or your personal doctor or other practitioners involved in your care. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

This Notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use health information about you to provide you with health treatment or services. We may disclose health information about you to doctors, nurses, technicians, health care students, clergy, or others who are involved your care. For example, an individual comes to the Agency to deal with a specific mental health issue. An intake worker may take some basic intake and assessment information, which would then be shared with a supervisor. Based on the preliminary assessment information, the supervisor will assign the case to a treatment professional and share existing information. The treatment professional in the process of developing a treatment plan, will gather additional information. This information may be shared with additional team members who are a part of your treatment team. Upon your discharge, the information may also be shared with those responsible for any aftercare services.

- **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at the Agency may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about services you received from the Agency so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Agency Operations**. We may use and disclose health information about you for Agency operations. These uses and disclosures are necessary to run the Agency and make sure that all of our clients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you or we or our designee may send you a patient satisfaction survey. We may also combine health information about many clients to decide what additional services the agency should offer, what services are not needed, and whether certain new treatments are effective. **We may also disclose information to doctors, nurses, technicians, health care students, and other Agency personnel for review and learning purposes**. We may also combine the health information we have with health information from other agencies to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific patients are.

- **Appointment Reminders**. We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or other services at the Agency.

- **Treatment Alternatives**. We may use and disclose health information to tell you about or recommend possible treatment options or alternative services that may be of interest to you.

- **Health-Related Benefits and Services**. We may use and disclose health information to tell you about health-related benefits, services, or health education classes that may be of interest to you.

- **Fundraising Activities**. We may use information about you to contact you in an effort to raise money for the Agency and its operations. We may disclose information to a foundation related to the Agency so that the foundation may contact you in raising money for the Agency. We would only release contact information, such as your name, address and phone number and the dates you received treatment or services at the Agency. If you do not want the Agency to contact you for fundraising efforts, you must notify our Privacy Officer in writing.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release health information about you to a care giver who may be a friend or family member. We may also give information to someone who helps pay for your care.

- **Research**. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Agency.

- **As Required Bv Law.** We will disclose health information about you when required to do so by federal, state or local law.

SPECIAL SITUATIONS

- **Organ and Tissue Donation**. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans**. If you are a member of the armed forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation**. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks (Health and Safety to you and/or others).** We may disclose health information about you for public health activities. We may use and disclose health information about you to agencies when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. These activities generally include the following:

    - to prevent or control disease, injury or disability;
    - to report births and deaths;
    - to report child abuse or neglect
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

- **Health Oversight Activities**. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

- **Law Enforcement**. We may release health information if asked to do so by a law enforcement official:

    - In response to a court order, subpoena, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct at the agency; and
    - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Health Examiners and Funeral Directors**. We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information

about clients of the Agency to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities**. We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others**. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state.
- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

  To inspect and copy health information that may be used to make decisions about you, you must submit this request in writing to the Client Records Department at

  _____
  _____.

  If you request a copy of the information, we will charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. A licensed health care professional chosen by the Agency will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend**. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Agency.

  To request an amendment, your request must be made in writing and submitted to the Director of Client Records. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- Is not part of the health information kept by or for the Agency;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures" under certain circumstances. This is a list of the disclosures we made of health information about you to others and which we are required to provide to you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Director of Client Records. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

- ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- To request restrictions, you must make your request in writing to the Director of Client Records. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communication, you must make your request in writing to the Director of Client Records. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Privacy Notice. You may ask us to give you a copy of this Privacy Notice at any time by requesting a copy from any member of our Agency staff.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at the Agency and on its website if it maintains a website. The Notice will contain on the first page, in the top right-hand corner, the effective date. Any time you would like another copy of the Agency's Privacy Notice, you are entitled to such Notice in paper form.

COMPLAINTS

If you believe your privacy rights have been violated, you may contact or submit your complaint in writing to the Privacy Officer at the Agency. If we cannot resolve your concern, you also have the right to file a written complaint with the Secretary of the Department of Health and Human Services. **The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.**

Concern/Grievance Form

If you have a concern or problem:

1. Discuss it verbally with the staff member first.
2. If you are unable to resolve the problem, you may fill out the top portion of this form and give it to the staff member's supervisor.
3. If the supervisor is unable to resolve the problem to your satisfaction, you have the right to contact the Program Manager/Agency Administrator who will make a final decision.
4. If the Program Manager/Agency Administrator is unable to resolve the problem to your satisfaction, we can assist you in contacting the regulatory agency/funder.

You will receive a written response for each step in the process.

Name: Date:

Contact Phone Number(s):

Staff Member: Program/Agency:

Please describe your concern:

for internal agency use only

Staff Member Response:

Supervisor Response:

Program Manager/Agency Administrator Feedback:

Return Copy to Quality Director

This guide to your Rights and Responsibilities is designed to help you get the best results from services offered by Catholic Charities.

Our agencies are committed to providing quality services for you and/or your family. We encourage you to participate in the programs that fit your needs. All services offered are subject to availability and you will not be refused admission or enrollment due to age, sex, race, or religious orientation.

Administrative Offices
4445 Lindell Boulevard
St. Louis, MO 63108

314.367.5500
www.ccstl.org

Supported by Annual Catholic Appeal — Serving Others

COA

United Way — United Way of Greater St. Louis

Your Program Contact Information:

Saint Louis Counseling
9200 Watson Road, Suite G101
St. Louis, MO 63126
314.544.3800
www.SaintLouisCounseling.org

Hours of Operation:
Monday-Thursday: 8:00 a.m. - 8:00 p.m.
Friday: 8:00 a.m. - 4:00 p.m.
Saturday: 9:00 a.m. - 2:00 p.m.
Hours may vary by location.

Your Rights Responsibilities

SAINT LOUIS COUNSELING

Catholic Charities
ARCHDIOCESE OF SAINT LOUIS
FEDERATION MEMBER

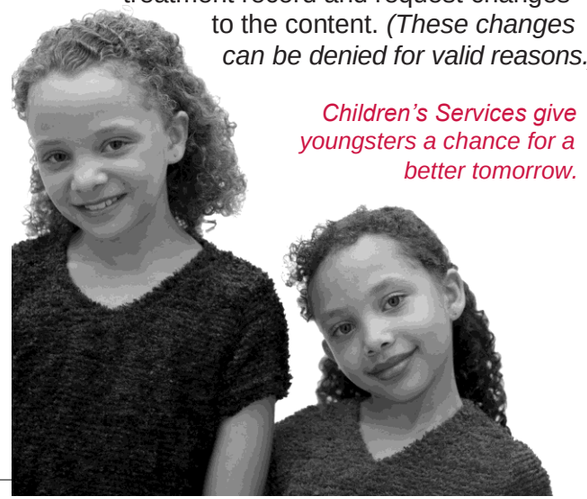
Dignity & Respect

Catholic Charities Archdiocese of Saint Louis has been helping people in need since 1912. Organized as a federation of various agencies, Catholic Charities has over 100 programs which assist more than 155,000 people annually at 50 sites.

Our services are provided without compromising your dignity, identity, or self-worth.

As a client, you have a right to:

- Your dignity and respect from others.
- Safety from harm or threat.
- Respect for your culture, values and needs.
- Receive services in a confidential and fair manner, without regard to race, gender, religion, nationality, or disability.
- Authorize the release of confidential information in writing, except for those areas listed in our Notice of Privacy Practices.
- Request information regarding your own treatment record and request changes to the content. *(These changes can be denied for valid reasons.)*



Children's Services give youngsters a chance for a better tomorrow.

- Know when legal requirements may result in the release of confidential information.
- Be treated as the primary source of information (legal guardian where applicable).
- Active involvement in planning and receiving services, building on your strengths and needs.
- Participate freely in decisions regarding services received.
- An explanation of available services and of related fees.
- Information when an appointment is delayed or postponed.
- Refuse services and understand the consequences of your refusal.
- Know the agency's concern/grievance procedure.
- File a complaint without consequences, regarding services being provided.

Service Providers have a right to:

- Treatment with dignity and respect.
- Safety from harm or threat.
- Take steps which might involve law enforcement officials when necessary to protect clients or others.
- Use general information for studies, fundraising, and for demographic and statistical purposes.

The agency that you are working with may have rights and responsibilities in addition to those listed. Additional policies for minors are available.

Protecting the sanctity of the family is the purpose of our Family and Community programs.

Clients are responsible for:

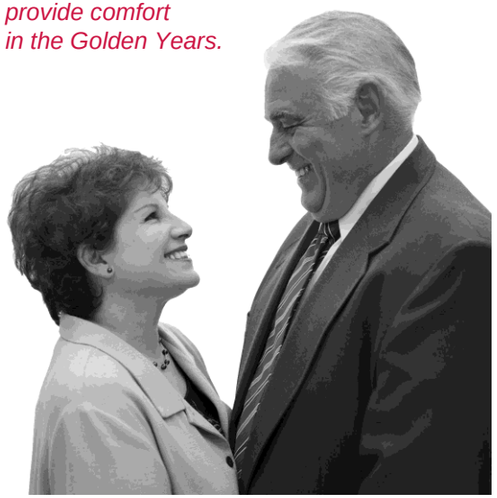
- Active participation in services, complying with program rules for alcohol and drug usage.
- Giving reasonable notice when an appointment cannot be kept.
- Respecting the rights of others who are providing or receiving services.
- Payment of any fees required for services.

Failure to fulfill these responsibilities could result in a client being discharged from the program.

Your Service Providers are responsible for:

- Treating clients and co-workers with respect.
- Arranging the appropriate services within the limits of the agency's resources, based on the client's needs and concerns.
- Maintaining confidentiality of all clients as outlined in our Notice of Privacy Practices.
- Informing clients of circumstances that would legally require the disclosure of confidential information as outlined in our Notice of Privacy Practices.
- Providing a safe environment.
- Reporting suspected abuse, neglect, violence or public health risks as outlined in our Notice of Privacy Practices.

Services for senior adults provide comfort in the Golden Years.



Responsibility