MINOR APPLICATION

Primary Client

First Name:_____ Middle:_____ Last:_____ Suffix:_____

Preferred Name/Nickname:_____ Gender: M / F DOB:___/___/_____ SSN:_____-____-_____

Home Address: _____ Apt. #: ____ City: _____ State: _____ Zip: _____

Race/Ethnicity (circle): *Hispanic/Latino Black/African American Asian Caucasian Other*_____

Country of Birth:_____ Languages Spoken at Home:_____ Religion:_____

Church/Parish:_____ School:_____ Grade:_____

Please list your main reason(s) for seeking help:_____

How did you hear about Cana Counseling? _____

Parent/Guardian/Stepparent #1

First Name:_____ M.I.:___ Last:_____ Suffix:____ Relation to primary client:_____

Gender: M / F DOB:___/___/_____ Marital Status:_____

Mailing Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____ ext.

Email:_____

Best way to contact (circle): CELL # / HOME # / WORK #

Parent/Guardian/Stepparent #2

First Name:_____ M.I.:___ Last:_____ Suffix:____ Relation to primary client:_____

Gender: M / F DOB:___/___/_____ Marital Status:_____

Mailing Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____ ext. ____

Email:_____

Best way to contact (circle): CELL # / HOME # / WORK #

*****Continue to page 2*****

Parent/Guardian/Stepparent #3

First Name:_____ M.I.:___ Last:_____ Suffix:____ Relation to primary client:_____

Gender: M / F DOB:___/___/_____ Marital Status:_____

Mailing Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____ ext. ____

Email:_____

Best way to contact (circle): CELL # / HOME # / WORK #

Parent/Guardian/Stepparent #4

First Name:_____ M.I.:___ Last:_____ Suffix:____ Relation to primary client:_____

Gender: M / F DOB:___/___/_____ Marital Status:_____

Mailing Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____ ext. ____

Email:_____

Best way to contact (circle): CELL # / HOME # / WORK #

Others who live in the home

1) Full Name:_____ DOB:____/____/_____ Relation to primary client:_____

2) Full Name:_____ DOB:____/____/_____ Relation to primary client:_____

3) Full Name:_____ DOB:____/____/_____ Relation to primary client:_____

4) Full Name:_____ DOB:____/____/_____ Relation to primary client:_____

5) Full Name:_____ DOB:____/____/_____ Relation to primary client:_____

Custody Details

If there is a custody arrangement in place for the primary client, please state the details of the arrangement below:

_____

_____

Emergency Contact

Full Name:_____ Relationship to primary client:_____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____ ext. ____

Best way to contact (circle): CELL # / HOME # / WORK #

Cana Counseling of Catholic Charities, Inc.
PARENT REFERRAL AND SOCIAL HISTORY FORM
CONFIDENTIAL

Client:_____ **Grade:**_____ **Today's Date:**_____

Form completed by:_____ **Relationship to client:**_____

The information you provide is very important to help us understand your child. Please mark all items that apply to this client and provide information requested.

1. School issues and behaviors:

	Poor		Fair		Good	Comments
Attitude towards school	1	2	3	4	5	_____
Relationship with teachers	1	2	3	4	5	_____
Completing work at school	1	2	3	4	5	_____
Completing homework	1	2	3	4	5	_____
Attention span	1	2	3	4	5	_____
Attendance	1	2	3	4	5	_____
Grades	1	2	3	4	5	Usual grades:_____

2. School history:

Number of schools attended since started school: _____
☐ Retained in _____ grade(s). Reason: _____
☐ Suspended in_____ grade(s). Reason: _____
☐ Expelled in _____ grades(s). Reason: _____
☐ Learning disability. Type:_____ ☐ ILP for _____

3. Describe social relationships at school:

☐ Gets along well with others ☐ Withdrawn/isolated ☐ Lies to others
☐ Physically aggressive ☐ Verbally aggressive ☐ Tattles on peers, siblings
☐ Shunned by classmates ☐ Many friends ☐ One good friend
☐ Teased by others ☐ Bullied by others ☐ A "loner"
☐ Prefers to be with adults ☐ Easily hurt/sensitive ☐ Shy

4. Parent/Guardian involvement with school:

☐ Very involved ☐ Somewhat involved ☐ Not involved
☐ Conflict with school ☐ Good teamwork between parent/teacher

5. Family/Home Life:

☐ Parents are married ☐ Single parent household ☐ Blended family
☐ Parents are divorced ☐ Parents are separated
☐ Lives with grandparent(s) ☐ Other living situation (describe):_____

If separated or divorced, who is primary custodian? _____
What is visitation schedule? _____

6. Relationships at home with:

	Poor		Fair		Good	Comments
Mother	1	2	3	4	5	_____
Father	1	2	3	4	5	_____
Brothers/Sisters	1	2	3	4	5	_____
Step-parent(s)	1	2	3	4	5	_____
Step-siblings	1	2	3	4	5	_____
Grandparent or other family	1	2	3	4	5	_____

7. Describe general mood of child:

☐ Happy ☐ Confident ☐ Angry ☐ Unemotional
☐ Sad, depressed ☐ Fearful ☐ Defiant ☐ Other_____

8. Medical History/Personal habits:

☐ Generally healthy ☐ Small for age ☐ Sleeps well ☐ Vision problems
☐ Physically inactive ☐ Large for age ☐ Trouble falling asleep ☐ Wears glasses
☐ Physically active ☐ Overweight ☐ Hard to wake up ☐ Hearing problems
☐ Overactive ☐ Picky eater ☐ Has bad dreams ☐ Wears hearing aid
☐ Easily tired ☐ Overeats ☐ Sleepwalks ☐ Allergic to _____
☐ Often sick (explain)_____
☐ Recent change in health (explain):_____
☐ Regularly takes **medication** (list below):
Name of med _____ For what?_____
Name of med _____ For what?_____
Name of med_____ For what?_____

9. Student's Developmental History:

Birth	Toilet Training	Crawling/Walking	Talking/Speech
☐ Full-term ☐ Premature ☐ Normal delivery ☐ C-section ☐ Problems with pregnancy ☐ Adopted ☐ Exposure to drugs/alcohol ☐ Problems after birth	☐ Toilet trained at age ___ If toilet training not complete, describe: ☐ Wets/day ☐ Wets/night ☐ Soils/day ☐ Soils/night How often?	☐ Early ☐ Normal ☐ Late ☐ Good coordination ☐ Poor coordination ☐ Current or past physical or occupational therapy	☐ Early ☐ Normal ☐ Late ☐ Stutters ☐ Current or past speech therapy

10. Additional Family History:

Alcohol use by:	Drug use by:	Mental Issues:	Child has experienced:
☐ Father	☐ Father	☐ Father	☐ Emotional abuse (by _____)
☐ Mother	☐ Mother	☐ Mother	☐ Physical abuse (by_____)
☐ Child	☐ Child	☐ Child	☐ Sexual abuse (by_____)
☐ Other	☐ Other	☐ Other	☐ Neglect (by_____)

Comments about family history (including medical family history issues, environmental family issues, or mental health family issues):

11. Did your child's school recommend counseling? Why?

12. Please describe any recent changes in behavior, relationships, school performance or family situation.

13. What are your child's strengths or positive traits? (Please list at least 3.)

14. What goals do you have for your child's counseling?

15. PRIMARY CONCERN:
What is the primary issue or concern you have for your child (please make choice below)? Please be as specific as possible in describing the problem you are concerned about. On a scale of 1 to 5, circle the number that describes how severe the problem is <u>right now</u>.

PROBLEM:

- ❒ **Bullying/aggressive behavior**
- ❒ **Being bullied**
- ❒ **Grief/loss**
- ❒ **Social Interaction Issues**
- ❒ **Physical/emotional/sexual abuse**
- ❒ **Mental health concerns (i.e. depression, anxiety, ADHD, etc.)**
- ❒ **Adjustment to divorce**
- ❒ **Substance abuse**
- ❒ **School/classroom behavior**
- ❒ **Not minding/poor attitude**
- ❒ **Other**

1	2	3	4	5
Mild		**Moderate**		**Severe**

How have you and your child worked to resolve this problem already?

NOTE: If you have more than one problem you're concerned about for your child, please identify others below and rate how much of a concern those problems are.

PROBLEM:

- ❒ **Bullying/aggressive behavior**
- ❒ **Being bullied**
- ❒ **Grief/loss**
- ❒ **Social Interaction Issues**
- ❒ **Physical/emotional/sexual abuse**
- ❒ **Mental health concerns (i.e. depression, anxiety, ADHD, etc.)**
- ❒ **Adjustment to divorce**
- ❒ **Substance abuse**
- ❒ **School/classroom behavior**
- ❒ **Not minding/poor attitude**
- ❒ **Other**

1 2 3 4 5
Mild Moderate Severe

How have you and your child worked to resolve this problem already?

PROBLEM:

- ❒ **Bullying/aggressive behavior**
- ❒ **Being bullied**
- ❒ **Grief/loss**
- ❒ **Social Interaction Issues**
- ❒ **Physical/emotional/sexual abuse**
- ❒ **Mental health concerns (i.e. depression, anxiety, ADHD, etc.)**
- ❒ **Adjustment to divorce**
- ❒ **Substance abuse**
- ❒ **School/classroom behavior**
- ❒ **Not minding/poor attitude**
- ❒ **Other**

1 2 3 4 5
Mild Moderate Severe

How have you and your child worked to resolve this problem already?

Other Comments:

CONSENT TO TREAT

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in a mental health assessment Cana Counseling of Catholic Charities, Inc. The purpose of the assessment is to determine my current mental health needs and to develop treatment recommendations. Once the assessment is complete and a treatment plan has been formulated, I will be given the opportunity to review and discuss with my clinician the results of the assessment, the nature of my condition if any, and any treatment including alternatives to these recommendations.

I acknowledge having received a copy of the Client Rights and Responsibilities brochure, a copy of the agency brochure that outlines available services, and a copy of Catholic Charities Notice of Privacy Practices.

I understand that this consent is voluntary and that I can withdraw my consent to treatment at any time.

Permission is hereby given to Cana Counseling of Catholic Charities, Inc. to provide assessment and treatment to myself, minor child(ren), and/or ward(s) as listed below.

_____	_____
Signature of Client or Guardian	Date of Signature
_____	_____
Printed Name of Person Signing	Date of Birth
_____	_____
Name of minor child or ward	Date of Birth
_____	_____
Name of minor child or ward	Date of Birth
_____	_____
Name of minor child or ward	Date of Birth
_____	_____
Name of minor child or ward	Date of Birth
_____	_____
Name of minor child or ward	Date of Birth
_____	_____
Staff Witness Signature	Date of Signature

Cana Counseling of Catholic Charities
Client Fees and Payment Agreement

1. **COUNSELING FEES:** The fee for each Diagnostic Interview is $140. Each counseling session is $125 per 50-minute hour. I agree to be responsible for the payment of these fees as they apply.

2. **PAYMENTS:** I agree to pay my co-pay (or toward my deductible) or the sliding scale fee, whichever is applicable, on the date of service. I understand that I will not be allowed to schedule another appointment if I have an unpaid balance for two visits, unless another payment agreement has been made with the business office.

3. **COLLECTION OF UNPAID FEES:** I understand that Catholic Charities utilizes a collection agency for non-payment of client fees.

4. **CANCELLATIONS/NO-SHOWS:** I understand that I will be expected to pay **$20 for each appointment for which I do not cancel before 5:00 p.m. at least one business day in advance**. I understand that I will not be allowed to schedule another appointment if I cancel with less than one business day's notice **or** "no-show" two consecutive appointments unless I pay $20 for each missed appointment prior to rescheduling. Cancellations and "no-shows" represent a loss of opportunity to the agency to serve you and offer services to other clients.

5. **INSURANCE:** I understand that I am responsible for knowing the terms of my insurance coverage and for monitoring the accuracy of insurance payments. I understand that benefits quoted are NOT a guarantee of payment. If there are any questions regarding benefits I will contact the billing office prior to my counseling session. I understand that Cana Counseling will file my insurance claims as a service to me. I will be responsible for the **full fee** if I do not comply with any requirements that my insurance company may make of me, such as securing prior authorization for treatment. I will be responsible for the full fee if I have insurance that will cover services at this agency, but I elect not to use it.

6. **INSURANCE PAYMENT OF BENEFITS:** I authorize payment of benefits to be made on my behalf to Cana Counseling of Catholic Charities and allow Cana Counseling to release information to my carrier in order to have my account reimbursed by said carrier.

7. **COURT-RELATED FEES:** For court subpoena, court testimony, depositions, time spent traveling to and from court appearances, and time spent in preparation of all the aforementioned, the fees will be charged to the client at the rate of $125 per hour, plus reimbursement for incidentals for all out-of-pocket expenses with receipts to document such costs.

8. **CLINICAL ASSESSMENT REPORT:** Minimum time allocated is three hours for a total minimum cost of $375 for each **Immigration Hardship Letter**. There will be a charge of $125 per hour for any additional hours spent preparing these Clinical Assessments.

_____	_____	_____
Signature of Client or Guardian	Printed Name	Date
_____	_____	_____
Signature of Spouse (if applicable)	Printed Name	Date
_____	_____	_____
Signature of Witness	Printed Name	Date

Insurance Information:

1) Primary Insurance: _____ Customer Service Phone #: (_____)_____-_____

ID #:_____ Group #:_____ Employer:_____

Policy Holder's Name: _____ Date of birth: _____/_____/_____

2) Secondary Insurance: _____ Customer Service Phone #: (_____)_____-_____

ID #:_____ Group #:_____ Employer:_____

Policy Holder's Name: _____ Date of birth: _____/_____/_____

Household Income (before taxes and other deductions): For statistical purposes and grant funding, we are required to gather information noting the income ranges for ALL clients. Please indicate gross annual family income from all sources. Use the categories below as needed to find the total.

Head of household: $_____/mo. Spouse/significant other: $_____/mo. Other income: $_____/mo.

= _____ Total annual family income.

Total yearly gross income for household:

0-5,000	_____	30,001-32,500	_____	55,001-57,500	_____
5,001-10,000	_____	32,501-35,000	_____	57,501-60,000	_____
10,001-13,500	_____	35,001-37,500	_____	60,001-62,500	_____
13,501-15,000	_____	37,501-40,000	_____	62,501-65,000	_____
15,001-17,500	_____	40,001-42,500	_____	65,001-67,500	_____
17,501-20,000	_____	42,501-45,000	_____	67,501-70,000	_____
20,001-22,500	_____	45,001-47,500	_____	70,001-72,500	_____
22,501-25,000	_____	47,501-50,000	_____	72,501-75,000	_____
25,001-27,500	_____	50,001-52,500	_____	75,001-77,500	_____
27,501-30,000	_____	52,501-55,000	_____	77,501-80,000	_____

If your income exceeds $80,000, please write the amount here: $_____

*****Number of household members (or number of people who depend on above income): _____*****

Cana Counseling of Catholic Charities, Inc.

AUTHORIZATION TO OBTAIN/USE/DISCLOSE CONFIDENTIAL INFORMATION

Name: _____ **Last 4 of SSN:** _____ **Date of Birth:** _____

I hereby authorize Cana Counseling to:

☐ **disclose information to:** ☐ **obtain and use information from:**

Name/Organization: _____ Relationship to Client: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information Designated: (Client or Legal Representative, please **initial appropriate blanks**.)

_____ Summary of treatment to include dates of contact, diagnosis, prognosis, treatment plan, intake and discharge summary

_____ Psychiatric evaluation report (medications) _____ Psychological evaluation report

_____ Substance abuse treatment progress, KCPC, evaluation, treatment plan, discharge summary

_____ Medical records _____ School records

_____ Participate in sessions _____ Current needs and functioning level

_____ Appointments & Billing Information _____ Progress notes from _____ to _____

_____ Other (specify): _____ _____ Legal/probation/parole records

The Purpose or Need Is To: (Client or Legal Representative, please **initial appropriate blanks**.)

_____ Assist in evaluation, treatment, planning and service coordination care and services provision

_____ Assist the person(s) or organization to whom the disclosure is made in their provision of services.

_____ Other (specify):_____

This authorization <u>will remain effective for 365 days from date of signature</u>. I understand I may withdraw this consent at any time through a written notice to Cana Counseling Services. Withdrawing authorization does not cancel any action that has already been taken by Cana Counseling Services in reference to my authorization(s).

I have been informed that I have the right to withhold my authorization concerning release of confidential material relevant to me or to the person named above. I understand that I will be given a copy of this form for my records. It is expressly understood any/all methods of electronic transmission of this authorization and information to be disclosed or requested shall be as valid as the original. I understand that if the person or entity that receives the information designated above is not covered by privacy regulations, the information may be re-disclosed and no longer protected by those regulations.

Signature of Client: _____ **Date:**_____

Signature of Parent/Legal Representative: _____ **Date:**_____

Signature of Witness: _____ **Date:**_____

Prohibition of re-disclosure: This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. 45 CFR Part 2 prohibits you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is not sufficient for this purpose.

ORIGINAL—Client's Permanent Record; COPY—Client or Personal Representative

Cana Counseling
Catholic Charities, Inc.
NOTICE OF PRIVACY PRACTICES

Understanding Your Cana Counseling of Catholic Charities, Inc. Health Record Information

Each time you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record or Personal Health Information (PHI), serves as the following:

- Basis for planning your care and treatment.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that you actually received the services billed.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better client outcomes.

Understanding what is in your health records and how your health information is used helps you to:

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your Rights Under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed it, you have the following rights with regard to the information contained therein:

- Request restriction on uses and disclosures of your PHI for treatment, payment, and health care operations. The right to request restriction does not extend to uses or disclosures permitted or required under federal privacy regulations.
- If, however, you request a restriction be placed on a disclosure to a health plan responsible for payment, we must grant the request if the health information pertains only to a service for which we have been paid in full.
- Request that we communicate with you by alternate means, and if the method of communication is reasonable then we will grant the request.
- The right, with certain exceptions, to inspect and/or receive a printed copy of your treatment and billing records. **We reserve the right to charge a reasonable fee to accommodate such requests.**
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access.
- If we deny you access, then we must provide you a review of our decision. These "reviewable" grounds for denial include the following:

  A licensed healthcare professional, such as your therapist, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.

  PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.

  The request is made by your personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.
- Request amendment/correction of your health information. We do not have to grant the request if the record is accurate and complete.
- Obtain an accounting of non-routine uses and disclosures, those other than for treatment, payment, and health care operations. We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. We do not need to provide an accounting for the following disclosures:
  - Disclosures made to you.
  - Disclosures that you authorized
  - To persons involved in your care as provided in 164.510 of the federal privacy regulations

Our Responsibilities under the Federal Privacy Standard

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms in this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) and notify you if we determine a breach of your PHI has occurred.

Other Uses and Disclosures

Other uses and disclosures require your written authorization. **This authorization may be revoked or amended at any time by you**.

Changes to this Notice

We reserve the right to change this notice at any time.

How to Get More Information or to Report a Problem

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law. If you believe your rights, with respect to health information about you, have been violated by Catholic Charities, you may file a complaint with Catholic Charities by contacting the person listed below or with the Secretary of the Department of Health and Human Services (HHS). All complaints must be submitted in writing.

Maintaining the privacy of your health information is very important to us. If you have any questions, concerns or would like more information about this notice, please contact:

HIPAA Privacy/Security Officer
437 N. Topeka
Wichita, Kansas 67202
(316) 264-8344

You will not be penalized in any way for filing a complaint.

Updated April 2018

Our Pledge

We respect our clients' privacy of personal information and are committed to maintaining our clients' confidentiality in a manner consistent with Catholic Charities' policies and applicable law. This information is collected to provide you with quality service and to comply with legal and statistical requirements.

Catholic Charities, Inc.
437 N. Topeka
Wichita, KS. 67202
(316) 264-8344

Mission

Inspired by God's love, Catholic Charities alleviates poverty and builds strong families in the Diocese of Wichita.

CANA COUNSELING
CATHOLIC CHARITIES, INC.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Catholic Charities
DIOCESE OF WICHITA

Serving all people
Helping renew lives

Client Rights and Responsibilities

About Our Program:
Catholic Charities' counseling services are offered to clients based upon client need, and do not discriminate on the basis of race, color, religion, national origin, gender, sexual orientation, age, or disability. Persons with challenges related to ability to pay and who do not have health insurance may apply for the sliding scale fee rate. Accommodations will be made for visual, auditory, linguistic, and motor limitations. Please let the receptionist know if you have special needs. We do have the right to refuse treatment or services if the client's needs exceed the range of the services we offer, or if the client refuses to follow agency policies.

Our office hours are 9:00 a.m. to 5:00 p.m., Monday through Friday. Evening appointments at 5:00 and 6:00 may be available on Mondays, Tuesdays, and Thursdays.

As a client of Cana Counseling at Catholic Charities, you have certain rights and responsibilities.

<u>Your Rights</u>:

1. **You have the right to be treated with respect and courtesy**. You have the right to adequate treatment and considerate care that respects your personal values, belief systems, and personal dignity.

2. **You have the right to know the fee before delivery of service begins. You also have the right to have bills and charges for services explained to you.**

3. **You have the right to confidentiality and respect for your privacy.** Details about how we use your confidential information and how you can give or withhold consent for us to use that information or share it with others are described in the NOTICE OF PRIVACY PRACTICES, which we will give you. We may release confidential information without client consent in situations such as: suspected abuse of a child, elderly, or disabled person, suspected threat of danger to self or others, or when court ordered.

4. **You have the right to know about your treatment and to be involved in decisions about your treatment including planning for discharge.** We will provide you with an explanation about for the treatment or services we recommend, the reason for such treatment/services, and any known risks and/or benefits of the treatment/services. Please know that the practice of psychotherapy is not an exact science and that the results cannot be guaranteed. No promises can be made about the results of treatment. You also have the right to know the eligibility requirements for our services.

5. **You have the right to refuse any form of treatment.** If you refuse a recommended service, we will inform you about the potential risks and consequences of your refusal. If you are an involuntary client (committed to treatment by a court order) you have the right to an explanation of the possible legal consequences of refusal.

6. **You have the right to have your clinician consult with your primary care physician or psychiatrist, when appropriate, to ensure treatment continuity and to determine if there is a medical condition or medication that may be causing or contributing to your symptoms.** It is a requirement of all clinicians that they consult with your doctor, unless you waive this right as will be discussed further with your clinician.

7. **You have the right to know the name and the credentials of the person providing your services**. **You also have the right to request a referral or different clinician within the limits of the agency's ability to provide the change in staff at any given time.** If you are not satisfied with your treatment or treatment provider, please discuss this with your clinician or notify the Program Director.

8. **You have the right to know that Catholic Charities staff will discuss cases for supervision purposes only to ensure best practice standards are being met.** In cases where multiple members of the same family are being seen by different clinicians, these clinicians may discuss the case amongst themselves in order to ensure that the best treatment options are being considered. You may waive this condition in writing at any time.

9. **You have the right to our services while seeing a psychiatrist/physician/medication provider.** Understand that no Catholic Charities staff member is authorized to practice medicine, surgery, or to prescribe medications.

10. **You have the right to know approximately how long you will be in treatment.** Your clinician can provide you with an estimate of the time required to address your particular needs.

11. **You have the right to Review your case record and amend your record, although there may be certain legal restrictions on these rights.** Some of these are described in the NOTICE OF PRIVACY PRACTICES.

12. **You have the right to make a written complaint or grievance if you think we have violated any of these rights or you have a concern about any other matter.** If you have a complaint, problem, or grievance, you should immediately talk to your clinician about it. If that does not resolve your concern, ask to speak to your clinician's supervisor. You may also ask for a written copy of the Client Grievance Procedure policy for additional steps to take.

You have the responsibility to:

1. Provide information needed for your treatment. It is very important that you honestly and openly tell us how you feel, what your needs are, your history, and why you are seeking treatment/services.
2. Participate in developing your treatment goals and plans with your clinician, and to follow that plan.
3. Attend your scheduled appointments and actively cooperate with and participate in treatment and services.
4. Let us know if a crisis or emergency situation exists.
5. Tell us if you are dissatisfied with our services, beginning with talking directly to your clinician.
6. Keep your appointments, or **cancel before 5:00 p.m. at least one business day in advance.**
7. Let us know if your name, contact information, financial situation (if using the sliding scale), or insurance information changes.
8. Honor your payment agreement. Outstanding balances that are not kept current may be referred to a collection agency.
9. Tell your clinician about any changes in your physical health or medications.
10. Arrange for care of your children while you receive services.
11. Treat staff and other clients with courtesy and respect.