Catholic Charities
Diocese of Covington

General Consent

I HAVE BEEN GIVEN A COPY OF CATHOLIC CHARITIES' *"NOTICE OF PRIVACY PRACTICES"* AND A COPY OF *"CLIENT RIGHTS & RESPONSIBILITIES"*.

I understand that the services that I will receive while a client of Catholic Charities (Provider) are contingent upon my signature on this consent document.

Please complete the following information:

In case of an emergency I authorize Provider to contact _____ at (____)_____. My relationship to this contact is _____.

Provider may send billing statement and any other necessary communication using the following (1 of these must be marked)

□ email _____

or

□ USPS mail _____

I wish to be contacted by Provider in the following manner (please check all areas that would be an acceptable manner to contact you);

□ Please contact me on my home telephone: (____) _____-_____.

□ Provider may leave their name and phone number only when they call on a machine or with a person.

□ Provider may leave a detailed message when they call on a machine or with a person.

□ Please contact me on my cellular telephone: (____) _____-_____.

□ by text □ leave voicemail □ can text appointment reminders

□ Provider may leave their name and phone number only when they call on a machine or with a person.

□ Provider may leave a detailed message when they call on a machine or with a person.

□ Please contact me at work: (____) _____-_____.

□ Provider may leave their name and phone number only when they call.

□ Provider may leave a detailed message when they call.

□ Provider may fax me information: (____) _____-_____.

□ Provider may email me at the following email address: _____

Client Printed Name _____

Client Signature_____ Date_____

Name of Authorized Personal Representative (if under 18) _____

Relationship to Client □ Parent □ Legal Guardian □ Other_____

Staff Signature_____ Date _____

CLIENT RIGHTS AND RESPONSIBILITIES

Catholic Charities
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Because of our interest assisting you in meeting your needs, and protecting you we are informing you of your rights in making use of our services, as well as important responsibilities which will help you to fully benefit from the particular service you will be receiving. You will be asked to read and sign this notice of Client's Rights & Responsibilities as well as a General Consent which allows Catholic Charities to share certain aspects of your protected health information for treatment, billing and health care operations. Your signature on these two documents will be necessary prior to receiving services.

RIGHTS

√ The right to know

You have the right to understand as completely as possible the intended results and effects of any professional service in which you participate. As professional human service providers, we are strongly committed to services where clients are seen as partners in an atmosphere of learning and growth. We will make every effort to develop a service plan with you which is responsive to your needs. We also encourage you to ask questions or to voice any concerns you have about the services you receive.

√ The right to confidentiality

Since the focus of our work together involves areas of your life that are sensitive and personal, we are committed to respect for your privacy and confidentiality. We cannot disclose any information that you have shared with us without your permission. We will only share information with others or receive records of your work with them if we have your written consent. Should I and/or my family members receive services from multiple providers at Catholic Charities, I give my consent for those providers to consult with each other in order to assure our best interests.

There are, however, legally required exceptions to this policy, one of which involves disclosure concerning abuse and neglect. As human service professionals, we are required by law and our professional ethics to report a reasonable suspicion of abuse or neglect to appropriate legal jurisdictions. In addition we are required to report our concerns should we suspect self-harm, or that you may harm another.

√ Graduate Internships

Catholic Charities is a training facility engaging graduate interns who bring with them the latest in technologies from accredited programs at the colleges and universities in our area. An intern may be assigned as your service provider. Should an intern be assigned as your service provider you will be informed.

√ The right to complain

If you are dissatisfied with your treatment or the services you receive, you have the right to contact the Executive Director and file a formal complaint. Should you choose to do so, you need to simply write or call the Executive Director using our normal telephone number. We treat these complaints very seriously and make every effort to resolve them in a just and fair manner.

√ The right to refuse or terminate service

Since the professional services which we offer are voluntary in nature, you have the right to say no to any recommendations or approaches that are offered to you. In addition, you also have the right to decide how long you want to make use of our services and to terminate that service. (See below: *Termination of Services)*

RESPONSIBILITIES

√ Keeping Appointments

You are responsible for keeping scheduled appointments for the services which you have requested. If you know in advance that you will need to cancel an appointment, you are expected to give twenty-four hours notice. Otherwise, you will be charged your usual fee for missed or late-canceled appointments. This policy, similar to those of most professional providers, is based on the loss of availability of services to other clients and the loss of professional staff time. *(There will be a $10 minimum charge for all late cancellations or missed appointments even though your particular service may be provided for no fee.)*

√ Paying Your Share

You are responsible for paying fees in accord with the agreement worked out with your service provider. There will be a fee (or part of a fee) for telephone services that are therapeutic in nature (beyond scheduling or rescheduling appointments, etc.). There is an ongoing expectation that you inform the service provider about increases and decreases in income, which could affect your fee. Though the inability to pay your fee on our sliding scale will not be a barrier to service, failure to pay an agreed upon fee may result in the discontinuation of service.

√ Termination of Services

If you decide to terminate service, we ask that you make this known directly to your service provider. While we respect your right to terminate services, ending can be an important step, so we encourage you to talk this decision over with your service provider.

It is your responsibility to maintain sobriety while participating in the programs and services of Catholic Charities. Should professional staff determine that you are impaired by a controlled substance, including prescription drugs that prevent you from being able to benefit from the service or are a danger to yourself or others, your appointment will be postponed until a later time. If appropriate, staff may offer a referral to a more extensive chemical dependency setting, or, should you be assessed as dangerously under the influence to legal authorities.

*Client signature:*_____ *Agency Representative:*_____

*Date:*_____ *Date:*_____

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Case Name_____ Case #_____

INITIAL INFORMATION (First Session)

1. Please write a few sentences about the concern that brings you here. (Presenting problem)

2. What do you hope/dream will be different or will change by your coming here? (Goal)

3. What are your resources or strengths that help you toward achieving your hopes or dreams? (Strengths)

4. What is keeping you from attaining your dream or hope for change? (Barriers)

Stress and Life Transitions can affect your physical health. We recommend that everyone have a preventative health care checkup each year.

5a. Have you seen your doctor in the last 12 months? ____Yes ____No

5b. Please rate your overall health, circle one: Excellent Very Good Good Fair Poor

6a. How many times in the past year have you had 4 drinks (women) 5 drinks (men) or more drinks in a day?
Never 1-3 times 4-6 times 6+

6b. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?
Never 1-3 times 4-6 times 6+

_____ _____
Client signature date Client/Parent signature (If Minor) date

_____
Therapist signature, credentials date

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Fee Agreement

Catholic Charities is a private, non-profit social service agency that is funded through donations, grants, fees and the United Way.

Payment for Services

Payment of the fee is expected at the beginning of each session. Any other payment arrangement should be discussed with your service provider. Monthly balances are to be paid within ten (10) days of the billing date.

Insurance

Catholic Charities accepts some insurance plans. Payment of co-pays, co-insurance, and any deductibles are expected at the beginning of each session.

Sliding Scale

A sliding scale is available for clients with no insurance. In order to determine the appropriate fee, the client will need to provide information and documentation.

Appointment Cancellation Policy

If you must cancel an appointment, we ask that you give your service provider at least 24 hours notice. You will be charged your *usual fee* for missed and late-canceled appointments. For services that are not charged a fee, there is a $10 charge for missed and late-canceled appointments. Since insurance cannot be billed for missed appointments and co-pays cannot be accepted for missed appointments, there is a $25 charge for our insurance clients for missed and late-canceled appointments.
Payment of these charges will be expected prior to the beginning of the next session.

Fee Agreement

I understand that my fee is $_____ per hour (or service) and that the payment of this fee is expected at the beginning of each session. (For Insurance clients, I understand this is my expected portion of the fee but could change based on insurance reimbursement). I understand that if I fail to pay the assigned fee, services will be terminated unless arrangement for payment is made. I also understand that this fee (or part of this fee) may be applied to telephone services that are therapeutic in nature.

Client (person financially responsible):_____Date:_____

Agency Representative:_____Date:_____

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Catholic Charities

AUTHORIZATION FOR RELEASE OF INFORMATON

Client Name:_____ DOB:_____ Case #:_____

Staff Contact (print) :_____ Staff phone, ext.: _____

I hereby authorize **Catholic Charities, Diocese of Covington, 3629 Church Street, Covington, KY 41015 ph: 859.581.8974 fax:859.581.9595**

TO ____ disclose copies of my records to: ____receive copies of my records from: ____ or exchange my medical information with:

Specific Person/Entity:_____Phone# _____Fax#_____

Full Address/City/Sate/Zip:_____

I authorize the following information to be released/obtained: __ Diagnostic Assessment

__Treatment Plan	__Diagnosis	__Attendance	__Psychiatric Eval
__Progress	__Urine Screen	__Progress notes	__Psychiatric Progress
__Complete Record	__Neurological Eval	__ Psychological Test Results	__Current Medications/Medical History

__Other, Specify:_____

This authorization includes but is not limited to records relating to: Diagnoses and/or treatment for alcohol/drug abuse/related conditions, AIDS/HIV test results, HIV/AIDS, AIDS Related Complex ARC, diagnoses and/or treatment, diagnoses and/or treatment relating to other communicable disease and/or sexual abuse.

Records requested for time period of FROM (Date)_____TO Present_____

Initial below:

____This release will **expire in 1 year** unless an earlier date is specified here_____

____**All releases will expire 90 days after services are terminated** unless an earlier date is specified here_____

My refusal to sign this authorization will NOT affect my ability to obtain treatment. I understand that I have the right to shorten or lengthen the authorization period at any time, which will require a new release be written. I understand that I may inspect or copy the information to be used or released and a fee may be applied. I also understand that I have a right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that Catholic Charities, Diocese of Covington has already taken action in reliance on my authorization.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal Regulations. The general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of (Clients/Parent/Guardian/Personal Representative-**Circle One**) Date

_____ _____

Signature of staff, credentials Date

If I revoke this authorization in writing, I may do so by completing the designated section below or by submitting a written statement to my therapist/worker. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal or state health information privacy laws, they may further release the protected health information, and it may no longer be protected by these laws.

Revocation:

I hereby revoke consent: _____ _____

Client/Parent/Guardian/Personal Representative and Date Signature of Person Witnessing Revocation and Date

THE CLIENT MUST BE OFFERED A COPY OF THIS RELEASE ONCE SIGNED.

A fax of this signed document may be accepted in lieu of the original.