HIPAA NOTICE OF PRIVACY ACKNOWLEDGEMENT

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Notice of Privacy Practices of RMYA Family Counseling & Resource Center may use/disclose information about the client. Not all situations will be described. RMYA is required to give you notice of HIPAA Notice of Privacy Practices for the information we collect and keep about the client.

THE NO SURPRISE ACT: No Surprises Act and Good Faith Estimate

Under Section 2799B-6 of the Public Health Service Act

The "No Surprises" requirements are effective as of January 1, 2022, and protect uninsured or self-pay consumers from many
unexpectedly high medical bills.

If you aren't using insurance to pay for your care, let your health care provider know in advance. Usually, the provider must give
you a good faith estimate of expected charges.

This applies when you don't have insurance or are choosing not to use it. You may choose not to use insurance if the service you
need isn't covered, or it's less expensive if you pay out of pocket.

In most cases, providers and facilities must give you an estimate when you schedule care at least 3 business days in advance, or
if you ask for one.

If a bill from one of your providers is at least $400 more than the good faith estimate from that provider, you can dispute your bill.

Note: You won't get an estimate during emergency care.

https://www.cms.gov/nosurprises
https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing

The information provided here is for general informational purposes and not intended to serve as legal advice or opinion.

_____ _____
Client name Date

_____ _____
Self/Legal Guardian Signature Date

Update 2024

Children's Residential Care & Counseling

CLIENT INFORMATION

SERVICE OF: ☐ Counseling ☐ UTHSCSA-Psychiatric Services (Partnership) ☐ Parenting Class ☐ TurningPoint

CLIENT INFORMATION (up to the age of 24):

Name: _____ **Age:** _____ **DOB:** ____/____/____ **SSN#:** ____/____/____

Gender: ☐ Male ☐ Female **Preferred Pronouns:** ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ Prefer Not to Disclose

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic ☐ Prefer Not to Disclose

Primary Language: ☐ English ☐ Spanish ☐ Other _____

School: _____ **Teacher:** _____ **Grade:** _____

CLIENT (18-24)/PARENT/LEGAL GUARDIAN INFORMATION:

Name _____ Age _____ DOB: ____/____/____ SSN#: _____/_____/_____

Gender: ☐ Male ☐ Female Address: _____

City _____ State _____ Zip _____

Phone Home _____ Cell _____ Work _____

Preferred number to contact: ☐ Home ☐ Cell ☐ Work
I authorize the clinic to contact me through my preferred methods of communication which may include phone calls emails and text messages for the purpose of appointment reminders, treatment updates and health information. I understand that my contact details will be used responsibly and protected under a confidential agreement. Initial: _____

Email address _____@_____

Relation to child: ☐ Biological Parent(s) ☐ Adoptive Parent ☐ Foster Care ☐ Power of Attorney

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married

Employment: _____ Occupation: _____

Legally we may not see your child until you provide all required documents:

☐ Photo I.D. of legal guardian
☐ Insurance card
☐ Legal documents related to the Custody of your child: Divorce Decree, Separation Affidavit, Child Support, Power of Attorney, Foster Care Placement and Adoption documents signed by a Witness, Judge or State of Texas Caseworker.

Please initial you have read and understood the above statement to provide the listed documents to be seen by a counselor: _____

EMERGENCY CONTACT:

Name: _____ Relationship to Client _____

Phone: _____

3103 West Ave. San Antonio, Texas 78213 | P: (210) 340-7971 ext. 1100 | F: (210) 340-2232|crc@rmya.org

Children's Residential Care & Counseling

CLIENT INFORMATION

Financial Information:

Insurance: ☐ No ☐ Yes ☐ Medicaid ☐ Superior/Traditional ☐ Community First ☐ Private _____

Annual Income:

☐ None ☐ Less than $5,000 ☐ $5,000-$9,999 ☐ $10,000-$14,999 ☐ $15,000-$24,999 ☐ $25,000-$34,999
☐ $35,000-$49,999 ☐ $50,000-$74,999 ☐ $75,000-$99,999 ☐ Equal/More than $100,000
☐ Prefer Not to Disclose

Family Structure:

☐ Single Parent/Caregiver family household w/children (no grandparent(s) present)
☐ Two Parent/Caregiver family household w/children (no grandparent(s) present)
☐ Family household with grandparent(s) responsible for grandchild(ren) present
☐ Other Family household
☐ Single person
☐ Other Non-Family household

Parent/Guardian/Individual(18-24) Education Level:

☐ Less than Kindergarten ☐ Kindergarten ☐ 1st Grade ☐ 2nd Grade ☐ 3rd Grade ☐ 4th Grade ☐ 5th Grade
☐ 6th Grade ☐ 7th Grade ☐ 8th Grade ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade ☐ 12th Grade
☐ High School Diploma ☐ GED ☐ Technical School ☐ Some College/No Degree ☐ AA/AS Degree ☐ BA Degree
☐ Graduate/Professional Degree

Military Service:

☐ Active Duty ☐ Reserve/National Guard ☐ Veteran ☐ Retired Military ☐ Military Dependent/Spouse
☐ Never Served

ADDITIONAL INFORMATION

How did you hear about RMYA:

☐ Family ☐ Friend ☐ Website ☐ Social Media ☐ Other: _____
Are you a Former/Current Employee: ☐ Yes ☐ No

Who Referred RMYA Services:

☐ Legal Guardian ☐ Court/Judge ☐ BCJP-Probation ☐ SAPD ☐ CPS-Caseworker _____

☐ School _____ ☐ Other _____

Have you consulted with a Counselor? ☐ YES ☐ NO

Dates: _____ Counselor/Psychiatrist: _____

Involvement with DFPS:

☐ Foster Care Conservatorship ☐ Juvenile Probation ☐ Family Conflict ☐ Emotional Behavioral Disturbance
☐ Runaway/Elopement History ☐ Aggressive/Assaultive Behavior ☐ Sexually Aggressive Behavior ☐ Truancy
☐ Self-Harm Behaviors ☐ Victim of Neglect ☐ Victim of Sexual Abuse ☐ Victim of Physical Abuse
☐ Other: _____

What issue/goal needs to be address:

_____

_____

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CONSENT: COUNSELING SERVICES

I, _____, (Client/Legal Guardian) request RMYA Family Counseling to provide the following services: **(Please INITIAL next to services requesting)**

1. _____ Counseling for Client/Child and Legal Guardian(s) to achieve Treatment Plan/Goals set with Clinician.

2. _____ Psychiatric Services – Client/Child and Legal Guardian(s) request to receive consent for psychiatric services.

3. _____ Family-centered trauma informed Parenting Program (classes)– Group/Individual fee applies.

Informed Consent:
I understand counseling **sessions may run 45 min(s) to 1 hour.** I understand I may see one of the following: Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor Associate, Licensed Marriage and Family Therapist Associate and Master Level Intern Students. Master Level Students provide the counseling services under supervision of a Licensed Professional. I understand the importance of attendance to achieve Treatment Plan/Goals per counseling session.

Financial Agreement for Services Rendered:
RMYA receives grants and private funding support that allows us to provide reduced cost for counseling services for clients seeking assistance.

We offer the payment options:

We accept the following Health Insurance:

Medicaid #_____ ☐ Superior ☐ Traditional ☐ Community First
Active verification at the time of counseling services intake process and/or appointments monthly.

Client may qualify for grant funded counseling services based on eligibility. We will determine eligibility at the time of an initial assessment for services.

If you are uninsured, not using insurance or don't qualify for grant funded services RMYA offers a sliding scale fee based on income:

- $40.00 per session with Licensed Professional Counselors/Therapist (LPC, LMFT)
- $20.00 per session with Licensed Professional Counselors/Therapist Associate (LPC-A, LMFT-A)
- No Charge (free) with Clinical Intern Students
- $70.00 Family-centered trauma informed parenting program (classes)

Limits of Confidentiality:
I understand the contents of counseling sessions are protected by Confidentiality. The Limits of Confidentiality are, but not limited to the following: 1.) Records may be subpoenaed by the courts. 2.) Allegations of physical abuse, sexual abuse and/or neglect are reportable to Child Protective Services. 3.) Assessments by the therapist in disclosure a child/client is a danger to self/others. 4.) Information about breaking the Law. 5.) At-Risk behaviors in relation to youth's safety, health, and well-being.

RMYA's Notice of Privacy Practices:
Please refer to RMYA's Notice of Privacy Practices to find out how protected health information about you may be used, disclosed and how you may access information. A copy of these policies will be made available to you upon request.

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CONSENT: COUNSELING SERVICES

Future Follow-up Contact: I understand RMYA Family Counseling & Resource Center will contact me after counseling has ended. The contact will be by phone, email, or mail. The follow-up will be to assess the home situation and changes since receiving counseling services. Attempts will be approximately 60 days after services were last provided.

RMYA Services offered in the Counseling Center:

- Counseling for Child, Young Adult and Family Crisis Intervention
- Psychiatric Clinic in Partnership with UTHSCSA-Psychiatric Program for Child and Young Adult.
- Parenting Classes by Group/Individual sessions.

Client Files: All client files are property of RMYA – Roy Maas Youth Alternatives.

Referred by an Agency: Before RMYA can verify attendance of sessions with a referring agency (i.e.: CPS/DFPS, BCJP, PCP, School...) at RMYA Family Counseling & Resource Center an Authorization of Release of Information form **MUST** be filled out and signed by the authorized consenter Legal Guardian/Client.

Canceling/Rescheduling Appointment(s): Please provide 24-hour notice canceling or rescheduling an appointment. Appointments may only be made after attending your Initial scheduled appointment. If a scheduled appointment is missed for at least **THREE** sessions with no contact as a ***NoCall/No Show*** all future appointments will be canceled. No showing for a minimum of **THREE** sessions consistently RMYA will contact you for continued services, if not RMYA will refer out to other agencies for provided services.

Suggestions/Compliments/Complaints: RMYA welcomes suggestions from our clients on ways to improve our services. Clients may call the Admin Office (210) 340-8077 or submit comments in writing to:
RMYA: Clinic Director, 3103 West Ave, San Antonio, Texas, 78213.

Authorized Person to transport youth for session: Adult authorized to transport my child to counseling session other than legal guardian in the event the legal guardian cannot make the session:

Name: _____ Relationship to client: _____

Name: _____ Relationship to client: _____

Verification of Guardianship for Professional Services Consent:
I verify that I am the Legal Guardian and have the right to consent for service. I acknowledge that I have read and understand the Consent for Services.

_____ _____
Signature of Legal Guardian/Client (18-24) Date

_____ _____
Print Client/Child Name Date

Client(s) ages 2-6: Please sign by circling below that you understand services provided and give consent for services: ☺ ☹

Client(s) ages 7-17: I am the minor client/child under the age of 18, I have been explained and understand the counseling services, I give my consent for services provided.

_____ _____
Signature of Client ages 7-17 Date

_____ _____
Signature of Therapist Date

Update 2024

Children's Residential Care & Counseling

Authorization of Release of Records

1. I authorize **Roy Maas Youth Alternatives (RMYA)** to disclose information relating to the medical, mental, and/or behavioral health condition and treatment of:

   Client Name: _____ DOB: _____

2. **The information is to be disclosed to** the following agency/facility, professional provider, or person:

   Provider/Agency/Group: _____

   Address: _____ City: _____ State: _____ ZIP: _____

   Contact Person/Dept.: _____

   Phone: _____ Fax: _____ Email Address: _____@_____

3. I authorize this information to be **disclosed using the following method(s)**:

   ☐ Written/Photocopy/Paper by Mail ☐ Written/Photocopy/Paper for Pick-Up ☐ Verbal ☐ Fax ☐ Electronic Mail

4. The **purpose for the release of this information** is:

   ☐ Insurance/Third Party Reimbursement ☐ Continuity of Care ☐ Pending Legal Action ☐ Other: _____

   If for Continuity of Care with another provider, records are needed by appointment date of: _____

5. **Dates of Treatment:** (MM/DD/YYYY): From: _____ To: _____

6. **Specific Information to be Released:** (check all that apply)

   ☐ Medical Records ☐ Diagnosis ☐ Education Records ☐ Records from Other Facilities ☐ Summary of Program Participation
   ☐ Entire Record; including, but not limited to information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities (except psychotherapy notes)

   ☐ Other (please specify): _____

   I give **specific authorization** to disclose information related to the following types of treatment:

   ☐ Psychiatric/Mental Health ☐ Drug/Alcohol Abuse ☐ HIV/AIDS ☐ Genetic Testing

7. **Revocation:** I understand that I may withdraw my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying RMYA in writing.

8. **Expiration:** Unless revoked, this authorization expires 1 year from the date I sign unless I specify another date: _____

9. **Conditions:** I release the person or entity named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. My treatment will not be based on the completion of this authorization form. I understand that it may take between 14 to 30 days for records to be released. I understand that the information to be released by this authorization may be re-released by the person or entity that receives it and may no longer be protected by Federal or Texas privacy regulations. I will be provided with a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____

Signature of Client/Legal Guardian/Authorized Representative **Date**

_____ _____

Printed Name of Client/Legal Guardian/Authorized Representative **Authority of Representative to Act for Client** (power of attorney, healthcare surrogate, etc.)

Note: Release of Psychotherapy Notes requires a separate authorization and/or court subpoena due to special protections of such records.

Update 2024

Audiotaping Consent

I, _____ (Client/Legal Guardian), give my authorization/consent to be audiotaped during this counseling session. I understand that during this session a counseling student intern will be recording, and a counselor will be present in the session. I understand this recording will be for educational purpose only and will be heard by the counseling student intern and supervisor/professor.

I, understand the following procedures are part of this agreement:

1. All material will be kept confidential with the class.
2. The participant will not be identified by name.
3. The tape(s) will be erased/destroyed at the end of the university's current academic semester.

The counseling student intern understands that if there are any questions/concerns at any time that they will meet with the Site Supervisor of RMYA Family Counseling & Resource Center

Limits of Confidentiality

During a recorded session confidentiality still applies with the counseling student intern meeting with client/child. Reminder the limits of confidentiality are but not limited to the following:

1. Records may be subpoenaed by the courts
2. Allegation(s) of physical abuse, sexual abuse and/or neglect are reportable to Child Protective Services if a minor is under the age of 18 years old.
3. Assessments by the counselor, a client is a danger to self/others.
4. Information about breaking the law.
5. A resident of TurningPoint program, TurningPoint Staff may be informed a resident is a danger to self/others or is in violation of program rules and regulations.

Authorization for Audiotaping

I acknowledge that the counselor and counseling student intern has reviewed the consent for audiotaping of my session with client/child and I have been given the opportunity to ask questions.

_____ _____

Signature of Legal Guardian/Client (18-24) Date

_____ _____

Counselor Signature Date

_____ _____

Intern Signature Date

Update 2024

VOCA Form

Client/Child Name: _____ DOB: _____

Please check any that may apply if the client/family have had exposure to the following:

☐ Adult physical assault (aggravated/simple)
☐ Adult sexual assault
☐ Adult(s) sexually abused/assaulted as a child
☐ Arson
☐ Bullying (verbal/physical/cyber)
☐ Burglary
☐ Child physical (abuse/neglect)
☐ Child Pornography
☐ Child sexual abuse/assault
☐ Domestic family violence
☐ DUI/DWI incident
☐ Violation of Court order
☐ None Apply

☐ Human Trafficking: Labor
☐ Human Trafficking: Sex
☐ Identity theft/fraud/financial crime
☐ Kidnapping (Custodial/Non-Custodial)
☐ Mass Violence (Domestic/Foreign)
☐ Vehicle victimization (Hit & Run)
☐ Robbery
☐ Stalking/harassment
☐ Survivors of Homicide victims
☐ Teen dating victimization
☐ Terrorism (Domestic/Foreign)
☐ Hate crime: Racial/Religious/Gender/Sexual orientation

***Do any of these apply to your child:**

☐ Deaf/Hard of Hearing ☐ Homeless ☐ Immigration/Refugees/Asylum seekers ☐ LGBTQ+
☐ Veterans ☐ Disabilities: Cognitive/Physical/Mental ☐ Limited English proficiency ☐ None apply

_____ _____
Signature of Legal Guardian/Client (18-24) Date

_____ _____
Clinician Date

Update 2024

Children's Residential Care & Counseling

Resource Needs Assessment

Client/Child Name: _____ DOB: _____

Phone: _____ Email: _____@_____

Preference of Contact: ☐ Phone call ☐ Email

Please check all that apply below if you/family need assistance:

☐ Adult counseling services

☐ Assistance w/disabled children

☐ Autism services

☐ Baby Supplies

☐ Clothing assistance

☐ Dental services

☐ Educational materials

☐ Emergency shelter

☐ Employment services

☐ Food assistance

☐ None apply

☐ Health & Wellness

☐ Insurance

☐ Medical services

☐ Nutrition Education

☐ Parenting classes

☐ Housing Services

☐ Prescription assistance

☐ Psychiatric services

☐ Transportation assistance

☐ Vision assistance

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