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

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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: ____

Update 2024

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:

- $40.00 per session with Licensed Professional Counselors/Therapist (LPC, LMFT)
- $20.00 per session with Licensed Professional Counselors/Therapist Associate (LPCA, LMFTA)
- 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.

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

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Authorization of Release of Information

I, ____ (Client/Legal Guardian) give Roy Maas Youth Alternatives permission to disclose and receive only the information I have identified on this authorization form to the person(s) or entity I have named only for the purpose shared information listed below. I understand that this will include information relating to: (check, if applicable)

☐ AID/HIV ☐ Behavioral Health services/Psychiatric care ☐ Treatment for alcohol/drug abuse

Client Information:

Client Name: ____ D.O. B.: ______________________

Address: _____________________________________City: ______________State: ___________ Zip: _______________

Phone: ________________________________ ☐ Cell ☐ Home ☐ Work

The Information shall be disclosed to the following person(s) or entity:

Person of Contact/Agency Name: ____

Address: _____________________________________City: ______________State: ___________ Zip: _______________

Phone: ____ Fax: ____

Information to disclose:

☐ Treatment Plan ☐ Dates of Service ☐ Educational information ☐ Medical Information

☐ Testing Assessment ☐ Summary of Participation in the Program ☐ Psychological Assessment

☐ Other **(Specify):** ____

The information disclosed is for the following:

From **(Month/Day/Year)**: _____________________ To **(Month/Day/Year)**: ____________________________

Conditions of this ROI Release of Information: This authorization is valid for one year from the date signed unless revoked prior to the date. I may revoke this authorization in writing at any time. This authorization cannot be revoked to the extent that RMYA has acted in reliance on the authorization. This information may be re-disclosed by the person(s) or entity receiving the information.

____ ___________________

Legal Guardian/Client (18-24yrs) signature **Date**

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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

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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

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

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