8308 N. May Ave. Ste. 100 Oklahoma City, OK · Phone: (405)949-4200 · Fax: (405) 720-8686
www.deaconessadoption.org

Dear Prospective Clients,

Thank you for considering Deaconess Pregnancy and Adoption Counseling Center for your counseling needs. It is a privilege to get to walk with you, your family, and our community in providing compassionate and client-centered care. We provide individual, family, and group counseling for anyone who has been touched by foster care or adoption. We additionally provide counseling services for anyone who has or is currently experiencing issues surrounding fertility, maternal mental health, or attachment.

Below you will find our New Client Packet forms. Please complete these forms prior to your first session and bring them with you. We will review the documentation during your intake appointment; however, if you have questions regarding the forms please contact our office. If you need assistance completing the forms, we are happy to walk through them with you. We look forward to serving you.

Kindly,

Deaconess Pregnancy and Adoption Counseling Center

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Program Description

The following is provided for you to understand the nature of the qualifications and services offered by the Deaconess Pregnancy & Adoption (DPA) Counseling Center and your rights and responsibilities as a client.

1. **Service Description:**

   The Counseling Center services have been designed to meet the particular needs of people touched by foster care and/or adoption. The agency is committed to providing competent and ethical services to clients that are tailored to meet their individual or family needs. The ultimate goal of services is wholeness mentally, emotionally, and spiritually, as well as increased health in relationships for all clients served.

   Trauma-informed and culturally competent treatment modalities and interventions are used to promote the healing and recovery of all clients. DPA is a ministry of the Free Methodist Church of North America and as such is bound by the tenets of its Book of Discipline. Clients seen in the counseling center are offered faith-based care as an option but are in no way required to integrate faith in the therapeutic care they receive.

   The following services are offered:
   - Outpatient Behavioral Health Services
   - Case Management Services
   - Emergency Services
   - Community Outreach & Educational Trainings

2. **Admission Criteria:**

   Services of the DPA Counseling Center are provided to any person touched by foster care or adoption. Children, ages 0-18, and adults are served as individuals, family units, and/or in group therapy settings.

   Exclusions for services include individuals requiring residential-level services and in-patient treatment at time of referral. Referrals will be made to clients requiring a higher level of care while in treatment and the availability of outpatient treatment will be re-evaluated at discharge from higher level of care. Adults who are registered sex offenders will not be eligible for services as our agency is housed with a child placing agency.

   When a person is found ineligible for services, he/she will be informed as to the reasons. Recommendations will be made to the client regarding possible alternative services.

3. **Agency Therapists & Credentials:**

   Heather Hails:

   Licensed Clinical Social Worker #6463; Master's degree in social work; TF-CBT trained; Trust Based Relational Intervention Practitioner

   Michelle Hankey:

   Licensed Professional Counselor #5544; Master's degree in Marriage and Family Therapy; TF-CBT trained; Adoption Competent

Client Name: ____________________________

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Client Intake Form

Client Name: ____ Age: __________

Date of Birth: ______________ Gender: ____________ Relationship Status: ________________

Address: ____

City: ________________________ State: ____________ Zip: ____________________

Guardian(s) Name(s): ____

Phone (home): ________________________ Phone (cell): ________________________

Phone (other): ________________________ Primary Method of Communication: ________________

Email Address: ____

Nation/Tribe/Ethnicity: ____

Primary Language of Client: ________________________ Secondary Language: ________________

Referral Name: ______________________________ Phone: ______________________

Emergency Contact: ___________________________ Phone: ______________________

Client's/Family's Description of the Problem:
Client's/Family's Expected Outcome of Treatment:

Client Name: ______________________________

Family Relationships

Does the client have any children?

Name	Age	Date of Birth	Gender	Lives With?	Additional Information

Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)

Name	Age	Date of Birth	Gender	Relationship	Additional Information

Legal Custody Status

Explain legal custody status. Include clear identification of the legal guardians and current living circumstance:

DHS Custody ☐ **Yes** ☐ **No**

Name of Primary Worker		
Office Address:		City/State/Zip:
Phone (work):	Phone (cell):	Email:

OJA Custody ☐ **Yes** ☐ **No**

Name of Primary Worker		
Office Address:		City/State/Zip:
Phone (work):	Phone (cell):	Email:

Probation ☐ **Yes** ☐ **No**

Name of Primary Worker		
Office Address:		City/State/Zip:
Phone (work):	Phone (cell):	Email:

Client Name: ____________________________

Family History (select all that apply)						
	Mother	Father	Siblings	Biological Mother	Biological Father	Grandparents
Alcohol/Substance Abuse						
History of Completed Suicide						
History of Mental Illness/Problems such as:						
Depression						
Schizophrenia						
Bipolar Disorder						
Alzheimer's						
Anxiety						
Attention Deficit/Hyperactivity						
Learning Disorders						
School Behavior Problems						
Incarceration						
Other						
Comments:						

Client Health Information	
Primary Care Physician:	
Office Address:	Phone:
City/State/Zip:	Fax:
Date of last physical exam:	
Are you currently using tobacco products ☐Yes ☐No	
Are you interested in tobacco cessation or treatment referrals? ☐Yes ☐No:	
Are immunizations up to date? ☐Yes ☐No (explain):	
Allergies (Medication & Other):	
Current Medical Conditions:	
Current Medications (includes herbs, vitamins, over-the-counter, etc):	
Past Medications:	

Past Medical History including hospitalization/residential treatment (list all prior inpatient or outpatient treatment including RTC, group home, therapeutic foster care, aftercare, inpatient psychiatric, outpatient counseling)

Dates	Inpatient/Outpatient	Location	Reason	Completed? Y/N

Surgeries:

Any accommodations required? ☐Yes (specify): ☐No

Client Name: ____________________________

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Counseling Policies

The following is provided for you to understand the nature of the counseling relationship, the qualifications and services offered to by the Deaconess Pregnancy & Adoption (DPA) Counseling Center and your rights and responsibilities as a client.

1. **Counseling Relationship**
   We will treat you with respect and provide a safe and confidential environment in which to explore the concerns you bring to counseling. The goal of therapy is wholeness and recovery. We will assist you in identifying and exploring options open to you. Ultimately, the responsibility for change is within you.

2. **Fee Scale**
   The base fee for a 50-60 minute counseling session is $100 per session. We accept Medicaid and some forms of private insurance. If you are paying privately and unable to afford this base amount, a portion of the counseling fee may be covered by a grant. A *Counseling Grant Application* is available upon request. The fee for your sessions is $________ per 50/60 minute session. Payment is due at the time of service. Clients are seen by appointment only. See *Cancellation & Attendance Agreement* for further information.

3. **Services Offered and Clients Served**
   We function from a family systems perspective, utilizing the research and understanding of attachment theory to assist you and your child(ren) in finding healing and connection. We are a faith-based agency, but respect all religious beliefs and offer the choice of each client on whether or not they want to incorporate faith in the treatment process. We may employ approaches such as Trust-Based Relational Intervention (TBRI), Theraplay, EMDR, TF-CBT, and other narrative and cognitive techniques. Rebuilding trust and attachment between children and their parents is a primary focus. We work with a wide range of issues in individual, couple, family or group sessions.

4. **Code of Conduct**
   Our counselors are bound by state law to adhere to the Code of Conduct as set forth by their respective licensing boards.

5. **Privileged Communication**
   Federal HIPAA and state laws require that we will maintain confidentiality of your status as our client, and of all interaction which takes place within our sessions together. We are required by law to disclose some information obtained during counseling in certain situations. These situations are as follows:
   a. As mandated by law – court orders and subpoenas,
   b. To defend legal action against the therapist or center,
   c. If therapist believes there is need to prevent client from harming self or others,
   d. Suspected child or elder abuse/neglect,
   e. The client signs a release of information.

   An additional exception to confidentiality is when, consistent with professional practice and treatment planning, consultation with other medical or counseling professionals is considered

appropriate. Those professionals are also bound by laws of professional confidentiality. Complete confidentiality cannot be assured when using cellphones, fax or e-mail.

When working with couples or families, it is important for you to know that you as a unit, the couple or family, are considered the client. Therefore, should you desire release of records, it would be necessary for both of you or every participant of legal age to sign a release prior to releasing any information.

6. **Grievance Procedure**

In the event you have a grievance or concern that arises regarding the quality of services provided to you, please discuss the situation as quickly as possible with your therapist either in session or by phone. Formal grievance forms can be obtained from any staff member of the agency. Further information regarding the grievance procedure can be found in the *Grievance Procedure & Acknowledgement* included in this packet. Furthermore, all therapists and our Executive Director are licensed by the appropriate board for their profession in the State of Oklahoma. Formal grievance procedures can be found through the licensing board for each profession.

7. **Emergency Situations**

Sometimes, when dealing with issues in counseling, powerful feelings may surface which may lead to a crisis situation outside of the session. If this occurs when we are not readily available (i.e., after hours, weekends, holidays), please call 911 (request a CIT officer) or go to your nearest emergency room.

8. **Client Rights**

You have the right to be treated with dignity and respect in the counseling process. You have a right to privacy of your information except in situations as mentioned above that limit confidentiality. You have a right to a copy of your treatment record upon request for those 18 and older. Parents have the right to request a copy on behalf of their child unless specifically stated in legal document that this right has been limited or revoked. Please see *Client Rights* included in this packet for further information.

9. **Client Responsibilities**

You, the client, are a full partner in counseling. Your honesty and effort is essential to success. If, as we work together, you have suggestions or concerns regarding your counseling, we invite you to share those with your therapist so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, we will help you with the referral process. If you are currently receiving services from another mental health professional, it is important that you inform us of this and grant us permission to share information with this professional so that we may confer on our treatment plans.

10. **Physical Health**

Because physical and mental health are closely related, we recommend that clients schedule a complete physical exam if they have not had one within the past year. It is important that you provide a listing of current prescription and non-prescription medication you are taking and notify us of any changes in medication.

11. **Potential Risks**

It is important for you to know that participating in counseling has certain risks. For instance, other issues may surface that have not been previously in your awareness; or changes that you make may impact other aspects of your life, such as relationships with family, friends, etc. A possible risk within marriage and family therapy may be that as one family member changes, additional strain may be placed on the marriage or family unit if the other family members

are not involved in the change process. We will be available to assist you with these issues in the therapeutic process or to help you locate appropriate resources.

Your signature indicates that you have read and been given opportunity to ask for clarification. You also certify that you understand this document, particularly the limits of confidentiality and the potential risks, and have been provided the online *HIPAA Notice of Privacy Practices*.

Clients 18 and older must sign this as a consent to treatment. Clients, ages 14-17, may sign assent to treatment only; parent or guardian must sign consent.

In signing this document, you are providing your consent for evaluation and treatment by the DPA Counseling Center. This authorization may be revoked at any time by providing written notice to the agency.

____ ____________

CLIENT SIGNATURE DATE

____ ____________

PARENT/GUARDIAN SIGNATURE DATE

____ ____________

PARENT/GUARDIAN SIGNATURE DATE

____ ____________

THERAPIST SIGNATURE DATE

Client Name: ____________________

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Oklahoma Department of Mental Health and Substance Abuse Services

CONSUMER RIGHTS

Each consumer has the right to be treated with respect and dignity.

Furthermore:

- Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
- Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.
- No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.
- Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each consumer shall have the right to the following:
- Allow other individuals of the consumer's choice participate in the consumer's treatment and with the consumer's consent;
- To be free from unnecessary, inappropriate, or excessive treatment;
- To participate in consumer's own treatment planning;
- To receive treatment for co-occurring disorders if present;
- To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and
- To not be discharged for displaying symptoms of the consumer's disorder.
- Every consumer's record shall be treated in a confidential manner.
- No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.
- A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.
- Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
- No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

Client Name: ____________________

ODMHSAS: Office of Consumer Advocacy, E-Mail:
AdvocacyDivision@odmhsas.org
Local: (405) 521-4256 Toll Free: (866) 699-6605 Reachout Hotline (800) 522-9054

CLIENT SIGNATURE	DATE
PARENT/GUARDIAN SIGNATURE	DATE
PARENT/GUARDIAN SIGNATURE	DATE
THERAPIST SIGNATURE	DATE

Deaconess Pregnancy & Adoption

HIPAA Notice of Privacy Practices

This Notice of Privacy Practices ("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 Deaconess Pregnancy & Adoption (DPA).

DPA

Attn: Heather A. Hails

8308 N. May Ave. Ste. 100

Oklahoma City, OK 73120

This Notice will explain:

- How DPA may use and disclose your Protected Health Information (PHI);
- DPA obligations related to the use and disclosure of your PHI; and
- Your rights related to any PHI that DPA has or retains about you.

This Notice describes how DPA may use and disclose your PHI to carry out services, payment and/or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, which may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

DPA is required to abide by terms of this Notice. A copy is available at all service locations. DPA may change the terms of this Notice at any time. The new notice will be effective for all PHI that DPA maintains at all that time. DPA will provide you with any revised Notice by posting it on the Post Adoption Services section of our website and making it available at our facilities.

I. Uses and Disclosures of Protected Health Information (PHI)

On your first visit to a DPA counseling session, you may be asked to complete a new patient information form and you will be required to sign an acknowledgement of receipt of this Notice. A copy of the Notice will be made available to you. DPA may obtain, but is not required to, your consent for the use or disclosure of your PHI for service, payment and/or health care operations. DPA is required to obtain your authorization for the use or disclosure of your information for other specific purposes or reasons. Some of the types of uses or disclosures are listed below. Not every possible use or disclosure is covered, but all of the ways that DPA is allowed to use and disclose information will fall into one of its categories. Your PHI may be used and disclosed by your service provider, our office staff and others outside of our office that are involved in your care for the purpose of providing counseling service to you. Your PHI may also be used and

disclosed to pay your counseling bills and to support the operation of DPA's counseling program. The following are examples of the types of uses and disclosures of your PHI that DPA is permitted to take.

A. **Treatment:** DPA will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your PHI with a third party that has already obtained your permission to have access t*o* your PHI. For example, DPA may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. If a psychiatrist is treating you, DPA may disclose your PHI to her/him in order to coordinate your care.
B. **Payment:** Your PHI will be used, as needed, to bill and/or obtain payment for the services provided to you. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services recommended for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, DPA may need to provide your insurance plan information about treatment you received, so your insurance will pay for the services. DPAS may also provide you PHI to business associated, such as billing companies, claims processing companies, and others that process health care claims for our office.
C. **Healthcare Operations:** DPA may use or disclose, as needed, your PHI in order to support the business activities of DPA's counseling program. These activities include, but are not limited to: quality assessment activities, licensing, and employee review activities. In addition, DPA may use a sign-in sheet at the registration desk where you will be asked to sign your name. DPA staff may also call you by name in a lobby when your provider is ready to see you. DPA may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. DPA will share your PHI with third party "business associates" that perform various activities (e.g., attorneys, accountants, consultants, and others to make sure that DPA is in compliance with applicable laws.) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, DPA will have a written contract that contains the terms that will protect the privacy of your PHI.

II. Uses and Disclosures of Protected Health Information Without Your Written Authorization

DPA can use or disclose PHI about you without your consent or authorization when:

- There is an emergency or when DPA is required by law to treat you,
- When DPA is required by law to use or disclose certain information, or
- When there are substantial communication barriers to obtaining consent from you.

DPA may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

2. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
3. If disclosure is compelled by the client or the client's representative pursuant to the State's Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
4. To avoid harm. DPA may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
5. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if DPA determines that disclosure is necessary to prevent the threatened danger.
6. If disclosure is mandated by the State's Child Abuse and Neglect Reporting Law. For example, if DPA has a reasonable suspicion of child abuse or neglect.
7. If disclosure is mandated by the State's Elder/Dependent Adult Abuse Reporting Law. For example, if DPA has a reasonable suspicion of elder abuse or dependent adult abuse.
8. If disclosure is compelled or permitted by the fact that you tell DPA of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
9. For public health activities. For example: In the event of your death, if a disclosure is permitted or compelled, DPA may need to give the county coroner information about you.
10. For health oversight activities. For example: DPA may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
11. For specific government functions. For example: DPA may disclose PHI of military personnel and veterans under certain circumstances. Also, DPA may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
12. For research purposes. In certain circumstances, DPA may provide PHI in order to conduct medical research with your consent.
13. For Workers' Compensation purposes. DPA may provide PHI in order to comply with Workers' Compensation laws.
14. Appointment reminders and health related benefits or services. For example: DPA may use PHI to provide appointment reminders. DPA may use PHI to give you information about alternative treatment options, or other health care services or benefits offered through DPA or other agencies.
15. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
16. DPA is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.

17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. For example: when compelled by DPA compliance with HIPAA regulations.
18. If disclosure is otherwise specifically required by law

.

III. Uses and Disclosures of Protected Health Information That Require Your Consent or Authorization

1. Disclosures to family, friends, or others. DPA may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

IV. Other Uses or Disclosures of Protected Health Information

Other uses or disclosures not covered in this Notice will not be made without your written authorization, unless otherwise permitted or required by law. If you provide DPA with written authorization to use or disclose information, you can change your mind and revoke your authorization at any time, as long as it is *in writing*. If you revoke your authorization, DPA will no longer use or disclose the information. However, DPA will not be able to take back any disclosures that have been made pursuant to your previous authorization when such use or disclosure was made in reliance on the use or disclosure indicated in the authorization.

V. Your Rights Regarding Health Information About You

You have the following rights regarding PHI a Health Care Provider maintains about you:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is DPA's possession, or to get copies of it; however, you must request the copies in writing. Requests should be submitted to DPA's Privacy Officer for consideration. If DPA does not have your PHI, but knows who does, DPA will advise you how you may get it. You will receive a response from DPA within thirty (30) days of receiving your written request. Under certain circumstances, DPA may deny your request, and if so, DPA will provide you, in writing, the reasons for the denial. The response will also explain your right to have this denial reviewed.

If you request copies of your PHI, DPA will charge you no more than $0.25 per page. DPA may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost for production of the PHI, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that DPA limit how it uses and discloses your PHI. While DPA will consider your request, it is not legally bound to agree. If DPA does agree to your request, it will put those limits in writing and abide by them except in emergency situation or as otherwise required by law. You do not have the right to limit the uses and disclosures that DPA is legally required or permitted to make.

C. **The Right to Choose How Your PHI is Sent to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of regular mail). DPA is obligated to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

D. **The Right to Get a List of the Disclosures DPA Has Made.** You are entitled to a list of disclosures of your PHI that DPA has made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

DPA will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list provided to you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the description of the information disclosed, and the reason for the disclosure. DPA will provide the list to you at no cost, unless you make more than one request in the same year, in which case DPA will charge you a reasonable sum based on a set fee for each additional request.

E. **The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that DPA correct the existing information or add the missing information. Your request and the reason for the request must be made *in writing*. All requests should be sent to DPA's Privacy Officer. You will receive response within sixty (60) days of DPA's receipt of your request. DPA may deny your request, in writing, if it finds that the PHI is

- Correct and complete,
- Forbidden to be disclosed,
- Not part of DPA's records, or
- Written by someone other than DPA personnel.

DPA's denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and DPA's denial be attached to any future disclosures of your PHI. If DPA approves your request, it will make the change(s) to your PHI. Additionally, DPA will inform you that the changes have been made, and will advise all others who need to know about the change(s) to your PHI.

F. **The Right to Get This Notice Electronically by Email.** You have the right to get this notice by email. You have the right to request a paper copy of it as well.

VI. Changes to this Notice

DPA reserves the right to change this Notice. DPA may make the revised notice effective for PHI it already has about you as well as any information it receives in the future. DPA will post a copy of the current Notice in all locations where clients receive services, The Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or apply for services with DPA for services, you will be offered a copy of the current Notice in effect. If you want to request any revised Notice, you may access it at our website, deaconessadoption.org.

VII. Complaints

If you believe your privacy rights have been violated you may:

A. File a complaint with DPA by contacting its Privacy Officer or Designee by dialing DPA main number (405) 949-4200 or by mail: DPAS, 7101 NW Expressway STE 325 Oklahoma City, Ok 73132.

B. File a complaint with the Secretary of the Department of Health and Human Services. You may call them at 877-696-6775 or write to them at 200 Independence Ave. S.W., Washington, D.C, 20201

All complaints must be submitted *in writ*ing. If you file a complaint against DPA's privacy practices, no retaliatory actions will be taken against you.

If you have any questions about this notice or any complaints about DPA's privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact:

DPA
Heather A. Hails
8308 N. May Ave. Ste. 100
Oklahoma City, Ok 73120

VIII. Effective Date of this Notice

This Notice went into effect on August 14, 2013

Client Name: ____________________

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www.deaconessadoption.org

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Federal HIPAA and state laws require that we will maintain confidentiality of your status as our client, and of all interaction which takes place within our sessions together. We are required by law to disclose some information obtained during counseling in certain situations. These situations are as follows:

a. As mandated by law – court orders and subpoenas,
b. To defend legal action against the therapist or center,
c. If therapist believes there is need to prevent client from harming self or others,
d. Suspected child or elder abuse/neglect,
e. The client signs a release of information.

An additional exception to confidentiality is when, consistent with professional practice and treatment planning, consultation with other medical or counseling professionals is considered appropriate. Those professionals are also bound by laws of professional confidentiality. Complete confidentiality cannot be assured when using cellphones, fax or e-mail.

When working with couples or families, it is important for you to know that you as a unit, the couple or family, are considered the client. Therefore, should you desire release of records, it would be necessary for both of you or every participant of legal age to sign a release prior to releasing any information.

I acknowledge that I have received a copy of Deaconess Pregnancy and Adoption's **HIPAA Notice of Privacy Practices**.

______________________________ ______________
CLIENT SIGNATURE DATE

______________________________ ______________
PARENT/GUARDIAN SIGNATURE DATE

______________________________ ______________
PARENT/GUARDIAN SIGNATURE DATE

______________________________ ______________
TREATMENT ADVOCATE SIGNATURE DATE

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www.deaconessadoption.org

Client Mailing Information

Child:________________________ **Date:**________________________

Parent/Guardian:____________________ **Therapist:**____________________

Please check for the following parties to receive mailings:

Parties:	NOT TO RECEIVE ANY INFORMATION	Invitations to Treatment Meetings	Service Plans	Discharge Summaries
Custodial Parent/Guardian				
Non-Custodial Parent				
Foster/Kinship Parent				
DHS Caseworker				
G.A.L.				
Probation Officer				
School District Contact				
Other				

Comments: ____

Client Name: ____________________

8308 N. May Ave. Ste. 100 Oklahoma City, OK · Phone: (405)949-4200 · Fax: (405) 720-8686
www.deaconessadoption.org

Communications Agreement

Texting Policy

Due to HIPAA regulations and the inability for your therapist to ensure your information is absolutely protected when sent electronically over text, we are asking that all clients not text any therapist, even regarding scheduling changes. All scheduling questions and information regarding the client being seen at the DPA Counseling Center should be discussed in person or over the phone at (405) 949-4200 during business hours (9am-5pm CT, Monday-Friday). If you are attempting to reach a therapist after office hours regarding scheduling, please call the agency on-call phone at (405) 482-3820.

_____ *By providing my initials, I understand that texting is not HIPAA compliant. To protect all parties within the therapeutic relationship, texting will not be utilized by Connect Counseling therapists and/or clients as a form of communication.*

Email Policy

It is also important for you to know that communicating via email is not HIPAA compliant as messages could be recorded and/or stored by the company. Additionally, anyone who has access to the computer could potentially have access to the message. Communication via email will be limited to scheduling or adjusting appointment days and/or times. If you do choose to email your DPA Counseling Center therapist, please note that your therapist only has access to read and/or respond to email during business hours.

_____ *By providing my initials, I understand that email is not HIPAA compliant. Clients do have the option to email their therapist regarding scheduling questions; however, any other communication regarding concerns for treatment, symptoms, or the need for immediate support should be done by placing a phone call or in person.*

Emergency Information

Currently, the DPA Counseling Center does not have an on-call service. If you are experiencing a mental health emergency, please contact 911 (request a CIT officer) or go to your nearest emergency room. You can also call the NorthCare Crisis Intervention Hotline at (405) 858-2700.

____ ____________

CLIENT (14 OVER) DATE

____ ____________

GUARDIAN SIGNATURE DATE

____ ____________

THERAPIST SIGNATURE DATE

Client Name: ___________________________

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Grievance Procedure & Acknowledgement

It is the policy of the agency to maintain an open line of communication with clients and to afford each client adequate opportunity to express opinions, recommendations, and complaints. A grievance may be filed by any DPA Counseling Center client. A grievance may also be filed by or on behalf of an agency client by any person who knows the client and is interested in the client's welfare, including, but not limited to, a parent, guardian, relative, foster parent, court-appointed special advocate, guardian ad litem, case worker, and others. This includes DHS employees, employees of residential, in-home supports, and vocational providers. The grievance shall be made on the *Client Grievance Form* provided by the agency or in writing as supplied to any staff member. Any person who needs assistance in completing the *Client Grievance Form* will be given assistance by any staff member.

1. **Processing the Grievance Form:**
   After completing a *Client Grievance Form*, the grievant submits the form directly to an agency employee. If someone other than the Counseling Supervisor or Executive Director receives a grievance, the grievance is submitted directly to the Counseling Supervisor or Executive Director within 24 hours of receipt. A copy of the completed *Client Grievance Form* will be provided to the grievant by the staff member receiving the grievance. After review of the grievance, a copy of the *Client Grievance Outcome* will be provided to the grievant. The results of the grievance may be picked up in person or results will be mailed to the grievant via the address they provide.

2. **Grievance Time Limits:**
   In order to be processed for action and resolution, a grievance must be filed within 14 working days of the date of the incident, decision, act, or omission complained about in the grievance, or within 14 working days of the date the grievant becomes aware of or, with reasonable effort, should have become aware of an issue. The time limit for filing a grievance may be extended by the agency.

   A. All original grievances should be addressed immediately and a suggested solution be provided on the *Client Grievance Outcome* form within seven (7) days of receipt. This response is provided along with a copy of the *Client Grievance Appeal* form in the event the client does not agree with the proposed resolution.

   B. An appeal may be made by returning the *Client Grievance Outcome* form via email, mail, or be hand-delivered with the bottom section completed noting the client's satisfaction or dissatisfaction with the proposed resolution. The client may also complete a *Client Grievance Appeal* form or send an email or letter delivered to any agency staff member to appeal the outcome.

   C. All grievance appeals, whether to the original response or subsequent appeals must be sent to the agency within five (5) days of receipt of the suggested resolution.

   D. Any grievance that is unable to be resolved at the agency level will be referred first to the President of the Butterfield Memorial Foundation (BMF) and then on to the BMF Board of

Directors if another level of response is needed.

E. The filing time and all other time periods contained in this policy are counted in working days unless otherwise specified. In computing any period of time, the day of the incident, decision, act, or omission at issue is not included. The next calendar day is the first day of the time period. If the last day of the time period is a Saturday, Sunday, or federal holiday, the period is extended to the next business day.

F. Reponses, notices, and other documents issued during the processing of a grievance are delivered to the grievant in person or by mail at the last known address of the grievant. A grievance is considered administratively resolved when a correctly addressed letter sent to the last known address of the grievant with proper postage is returned undeliverable with no forwarding address.

G. There is no time limit on allegations of abuse, neglect, verbal abuse, exploitation, or caretaker misconduct.

H. There is no time limit on the filing of a grievance with the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS). There is no requirement that a grievant file with the DPA Counseling Center prior to filing a grievance with ODMHSAS.

3. **Retaliation Prohibited:**
No person filing a grievance shall be retaliated or discriminated against or harassed, solely or in part, for having asserted a grievance, or sought advice or inquired about filing a grievance. Clients are not discouraged from filing a grievance.

4. **Informal Resolution of Grievance:**
If the Counseling Supervisor or Executive Director is able to promptly resolve the grievance to the grievant's satisfaction without further processing, the Counseling Supervisor and/or Executive Director completes the appropriate section of the grievance form, signs it and files it in the appropriate grievance file.

5. **Administrative Problem Resolution:**
If the grievance has not been resolved to the grievant's satisfaction, the Counseling Supervisor and/or Executive Director refers the grievance to the next level of organizational hierarchy, the BMF President or his designee within two (2) working days of receipt of the appeal.

A. The BMF President or designee responds to the grievance within five (5) working days of receipt of the grievance. If the proposed resolution contains a promise of some future action, a target date is specified for full implementation of that future action. The grievant may contest the target date by taking the grievance to the next level of problem resolution.

B. Within five (5) working days of receipt of the grievance, the BMF President or designee meets with the grievant to inform the grievant of the proposed resolution and the right to further contest the grievance. They then present the proposed resolution and determine if the grievant is satisfied with the proposed resolution. The BMF President or designee may meet with the grievant along with the Counseling Supervisor and/or Executive Director.

C. If the grievant is satisfied with the proposed resolution, the BMF President or designee indicates the grievant's acceptance, notifies the individuals responsible for resolution of the grievance, and places the form in the appropriate grievance file.

Client Name: ____________________________

D. If the grievant does not accept the proposed resolution and desires to further contest the grievance, the BMF President or designee processes the grievance as a contested grievance in accordance with the following section.

6. **Contested Grievances:**
If the grievant does not accept the proposed resolution, the target date of the BMF President or designee, or both, the grievance is appealed to the agency's Board of Directors.

A. The BMF President or designee transmits a contested grievance and related documentation to the Board within five (5) working days of learning that the grievant does not accept the proposed resolution and is contesting the proposed resolution.

B. Within ten (10) working days of receiving a contested grievance, the Board responds to the grievant by submitting a written decision to the BMF President or designee.

C. Within two (2) working days of receiving the written decision of the Board, the BMF President or designee informs the grievant of that decision and provides the grievant with a copy of the written decision. This concludes the grievance process and the grievant's administrative remedies have been exhausted.

7. **Grievances filed with ODMHSAS Office of Consumer Advocacy:**
Grievants may file a grievance with the ODMHSAS Office of Consumer Advocacy at any time. There is no requirement that the grievant follow the above outlined procedures for administrative review of the agency prior to contacting or filing a grievance with ODMHSAS Office of Consumer Advocacy. If a grievant does not accept the final resolution of the BMF Board of Directors, they have the right to file a grievance with the ODMHSAS Office of Consumer Advocacy.

The DPA Counseling Center staff will actively assist clients in fling grievances with ODMHSAS Office of Consumer Advocacy as requested and serve as a resource for questions or information about the agency, policies, or other needs of the client. The agency will also communicate with the Office of Consumer Advocacy and any requests made for information.

The ODMHSAS Office of Consumer Advocacy may be reached at:
405-248-9037
1-866-699-6605 (toll free)
advocacydivision@odmhsas.org
2000 N. Classen Blvd. Ste. E600
Oklahoma City, OK 73106

8. **Contact Information:**
The following persons are responsible for ensuring the proper procedure of grievances and resolution takes place. In the event that a grievance is filed on one of the below-listed individuals, decision-making will be authority shall be delegated appropriately.

- Grievance Coordinator: Sarah Baird, Office Coordinator
- Resolution: Heather Hails, Executive Director
- Administrative Resolution: Hal Hoxie, President, BMF
- Local Advocate: Heather Hails, Executive Director

The local advocate serves in the capacity as an on-sight advocate for clients being treated or under the care of the DPA Counseling Center and acts as a liaison to the ODMHSAS Office of Consumer

Client Name: ___________________________

Advocacy. The local advocate can assist clients in filing grievances, serve as a resource for questions or information about the program, admission and discharge process, or basic human needs, and will contact clients who witness critical incidents or sentinel events while in treatment to ensure needs are met.

Your signature indicates that you have read and been given opportunity to ask for clarification regarding the grievance procedure. You acknowledge that you understand the grievance procedure of the DPA Counseling Center.

_______________________________________ _____________

CLIENT SIGNATURE DATE

_______________________________________ _____________

PARENT/GUARDIAN SIGNATURE DATE

_______________________________________ _____________

PARENT/GUARDIAN SIGNATURE DATE

_______________________________________ _____________

THERAPIST SIGNATURE DATE

Client Name: ____________________

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Cancellation & Attendance Agreement

To receive the maximum benefit of treatment, it is important that you attend each of your scheduled appointments and that you arrive on time.

Cancellation Policy

Providing the best care to each client requires that we do not overlook or double book our appointments. Unfortunately, missed appointments result in open slots in our therapists' schedules and are a lost opportunity to help other clients. While we understand emergency situations and circumstances when you must cancel, our agency requires a **$25.00 fee for appointments that are not cancelled within 24 hours of the scheduled appointment time.** This fee is your responsibility and must be paid prior to scheduling your next appointment. **Missing an appointment without prior notification *(no call/no show)* will require a fee equal to the full amount of the designated session fee.**

_____ *By providing my initials, I understand and agree to the Cancellation Policy*

Attendance Policy

Due to the need of our services in our community, we have an attendance policy. Your therapist will keep track of your excused (fever, throwing up, calling to cancel 24 hours before appointment time, etc.) and unexcused (forgotten appointment, non-severe weather, consistently not feeling well, missing appointment without notification, etc.) appointments missed. **If you have more than two excused appointments per month, you will be discharged from therapy.**

If you or your child incurs one unexcused appointment, a cancellation fee of $25.00 is required to be paid in cash before another appointment is scheduled. **If you or your child incur two unexcused appointments, you will be discharged from therapy**.

A letter will be sent to the address on file explaining the reason for discharge from our services. We do understand there are special circumstances that can occur and we will review those carefully when making the decision to discharge.

_____ *By providing my initials, I understand and agree to the Attendance Policy*

______________________________ ______________
CLIENT SIGNATURE DATE

______________________________ ______________
PARENT/GUARDIAN SIGNATURE DATE

______________________________ ______________
PARENT/GUARDIAN SIGNATURE DATE

Client Name: ____________________

____ ____________
THERAPIST SIGNATURE DATE

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Agreement to Pay for Professional Services

Client Name: ______________________

I/We, ______________________________________ request that the therapist named below provide professional services to me/us/my child and I/we agree to pay this therapist's fee of $100 per 50/60 minute session unless otherwise arranged with the DPA Counseling Center. This same fee will be applied per each hour of consultation, assessment, or other therapeutic activity unless otherwise negotiated in writing. I/we understand that payment will be accepted in cash, by check, or via credit card.

I/We understand that I/we need to cancel any appointment I/we cannot keep at least 24 hours in advance, otherwise I/we will be charged a $25.00 cancellation fee. I/We also understand missing an appointment without prior notification (no call/no show) will require a fee equal to the full amount of the designated session fee.

I/We agree that I am/we are responsible for the charges for services provided by this therapist to me/us, although other persons may make payments on my/our account. If any part of our fee is being paid by a third party payer, I/we understand that this may result in some limitation to our confidentiality.

I/We understand that **payment for services is due at the time services are rendered**, unless prior arrangements have been made with the Business & Financial Specialist. If I am/we are invoiced for unpaid services, it is understood that payment is due upon receipt. Unpaid balances exceeding 21 days will result in a suspension of services until account is paid in full.

____ ____________

CLIENT/PARENT/GUARDIAN SIGNATURE DATE

____ ____________

CLIENT/PARENT/GUARDIAN SIGNATURE DATE

I, the therapist, have discussed the issues above with the clients and believe they are fully competent to give informed and willing consent.

____ ____________

THERAPIST SIGNATURE DATE

Counseling Center
8308 N. May Ave. Ste. 100 Oklahoma City, OK · Phone: (405)949-4200 · Fax: (405) 720-8686
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Consent to Release of Information

I hereby authorize:
Person or Facility: ______________________________

____

Address: ______________________________

______________________________ Phone: ______________

to release information from records about ______________________, born on __________, and whose Social Security Number is ______________________, for the following purpose(s):

- ❑ Further mental health evaluation, treatment, or care
- ❑ Treatment planning
- ❑ Research
- ❑ Rehabilitation program development or services
- ❑ Other: ______________________

These records concern the time between ____________ and ______________.
In the boxes below, the information to be disclosed is marked by an X, Written dates indicate when those records were mailed to the requester.

- ❑ Intake and discharge summaries __________
- ❑ Medical history and evaluation(s) ____________
- ❑ Mental health evaluations _________
- ❑ Developmental and/or social history____________
- ❑ Educational records ___________
- ❑ Progress notes, and treatment or closing summary _______
- ❑ Other: ______________________________ ________

Select only one:

- ❑ Please forward the records to the address in the letterhead at the top of this form.
- ❑ Please forward the records to the address written above.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

______________________________ ______________________ ____________
Signature of client | Printed name | Date

______________________________ ______________ ________ ________
Signature of parent/guardian/representative | Printed name | Relationship | Date

______________________________ ______________ ________ ________
Signature of parent/guardian/representative | Printed name | Relationship | Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

______________________________ ______________________ ____________
Signature of witness | Printed name | Date

❑ Copy for patient or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records

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Consent for Treatment Advocate

All adult clients have the right to be informed of and the ability to consent to name or not name a treatment advocate. Treatment advocates can be family members or another concerned individual designated by the adult client. There shall be no coercion, directly or indirectly, or penalty to a client for choosing to name or not name a treatment advocate, their choice of advocate, as well as the level of involvement determined by the client. The client also maintains the right to revoke or reinstate a treatment advocate at any point and for any reason while therapy services are being provided.

I, ______________________________ request that the person named below be allowed to act as my treatment advocate. As my treatment advocate, the below-named may participate in treatment and discharge planning as allowed by me and indicated below. I understand I can contact my therapist to amend or revoke this consent at any time.

I hereby name the following as my treatment advocate:

____
Name of Treatment Advocate

____
Relationship to Client

____
Address of Treatment Advocate

______________________________ ______________________________
Phone Number of Treatment Advocate Email of Treatment Advocate

Involvement Level (check one):

□ Full Involvement (all treatment planning meetings, reviews, and discharge planning)

□ Partial Involvement as listed here: ______________________________

______________________________ ____________
CLIENT SIGNATURE DATE

______________________________ ____________
THERAPIST SIGNATURE DATE

By signing here, I accept the designation as a treatment advocate for the above-named client and verify that my role has been explained to me by the clinical staff. I intend to serve as the treatment advocate according to the specification listed above and understand the client has the right to amend or revoke this consent at any time. I have also been provided notice of HIPPA policies and agree to comply with all standards of confidentiality.

TREATMENT ADVOCATE SIGNATURE DATE

I hereby revoke this Consent for Treatment Advocate effective immediately.

CLIENT SIGNATURE DATE

THERAPIST SIGNATURE DATE