

FACE SHEET

Date: _____

Phone (H) _____ (W) _____

Alternative # _____

Name: _____

May we contact you at home? _____

Address: _____

at work? _____

Birth Date: _____ Age: _____

Referred by: _____

Place of Birth: _____

Family Income: \$ _____ *In order to qualify for United Way funding, we are required to collect this information. This data is collected for that purpose only. This will not affect the services received.*

Religious Tradition: _____ Practicing: _____ Yes _____ No

Marital Status:

Married _____ Separated _____ Single _____ Divorced _____ Widowed _____ Living with Partner _____

Name of Spouse/Partner: _____

CURRENT HOUSEHOLD MEMBERS

I am currently living alone: _____

Name	Relationship to Client	D.O.B.	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any children who do not live with you?

Yes ___ or No ___ Who: _____ Age: _____

Family of Origin Information:

Father _____ age _____ How many siblings do you have? _____
Mother _____ age _____ Where are you in the Birth Order? _____
Did your Parents separate/divorce? _____ yes _____ no
What age were you at the time of the separation/divorce? _____

Person to contact in case of an emergency: _____

Phone: _____

Relationship to you: _____

Education: (please check as appropriate): GED _____ Highest Grade Completed _____

High School _____ Vocational Training _____ College _____ Grad School _____

Employer: _____ **Position:** _____

Number of years with employer: _____

Please List any Past Counseling, EAP or Chemical Dependency Services:

Facility/ Counselor Name	When seen?	Why Seen?	Helpful?	
			Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

What concerns bring you to counseling now? _____

What changes do you want to see as a result of counseling? _____

**CATHOLIC FAMILY CENTER
EAP and Counseling Services**

CLIENT HEALTH INFORMATION

All information on this form is strictly confidential and will be utilized by your counselor only.

Name: _____ Date: _____

Name of Primary Care Physician: _____

Date of Last Physician Contact: _____

Reason for Office Visit: _____

Any current medical problems: **Yes No** Briefly describe: _____

Are you under the care of a physician for this problem? **Yes No**

Any past medical problems? **Yes No** Briefly describe: _____

List any allergies (especially to medications): _____

Any history of hospitalization for medical problems? **Yes No**

When: _____ Why: _____

Have you ever been hospitalized for emotional or psychiatric reasons? **Yes No**

Briefly describe: _____

Currently taking any prescription medications? **Yes No**

(State Type, Dosage and Purpose)

Type _____

Dosage _____

Purpose _____

Regular use of non-prescription drugs? **Yes No**

(State type, Frequency, Reason Taken)

Type _____

Frequency _____

Amount _____

Has Primary Care Physician or Psychiatrist prescribed medications for mood, anxiety or depressive symptoms? **Yes No**

When _____ Type _____

Reason _____ Dose _____

Any changes or problems with eating or appetite? **Yes No**
Appetite decrease _____ Appetite increase _____

Any recent changes in weight? **Yes No**
Pounds gained _____ Pounds lost _____

Any problems with getting to sleep? **Yes No**
Any problems staying asleep? **Yes No** Hours of sleep/night _____

Do you smoke? **Yes No**
If yes, how many per day? _____

Do you drink caffeinated beverages? **Yes No**
What? _____ How much? _____ How often? _____

Any history of accidents resulting in serious physical or emotional trauma? **Yes No**
Head injury? **Yes No**
What was the injury? _____
When? _____

Do you use alcohol and/or other drugs? **Yes No**
What do you use? _____ How much? _____
How often? _____

Any history of alcohol or substance abuse? **Yes No**
When? _____

Substance(s) used? _____

Have any family members ever been in treatment for, or do they have a history of, _____ mental health problems or _____ chemical dependence? **Yes No**

Who? _____

Please circle all that apply: **When I am under stress I often:**

Exercise	Read	Talk with friends
Smoke	Eat	Have a drink
Watch TV	Sleep	Isolate/Withdraw
Go out a lot	Work	Become irritable
Meditate	Use humor	Shop
Use the computer	Hit/throw things	Use Drugs
Hobby: _____		Other: _____

Client Signature: _____ Date: _____

CATHOLIC FAMILY CENTER

Counseling
TERMS OF SERVICE

Please take some time to read the following and sign at the bottom. If you have any questions ask your counselor.

- Hours are by appointment
Appointments are 50 minutes in length. This allows your counselor time to write a note and prepare for the next appointment.
Please arrive on time for your appointment. If your counselor starts your appointment late, you will still receive 50 minutes. However, if you are late, the appointment will end as scheduled.
Your confidentiality is a critical concern for us. Details regarding confidentiality are on the Client's Rights form. Please read it carefully and sign it at the end.
In the event that you need to reach your counselor, please call them at the phone number they give you. Understand that some counselors are part-time and they may not receive your message right away. If you are experiencing a crisis situation, and do not reach your counselor immediately, you can try our main office at (585) 546-3617. After hours and on weekends, please call the Department's after hours phone. The number is: 585-208-0191.
Self-Pay fees and Insurance co-pays are due at the time of service.
Notice must be given for cancellations- no less than 24 hours before scheduled appointment time. Failure to cancel an appointment without 24 hours notice (or on Friday for a Monday appointment) will result in a charge for the missed appointment.
Two (2) no shows or late cancellations may result in a 90 day hold before you will be able to schedule another appointment. This is part of our contract with your employer.

I have read and agree to the above Terms of Service.

Signature

Date

Witness Signature

Date

CATHOLIC FAMILY CENTER

STATEMENT OF MUTUAL RIGHTS AND RESPONSIBILITIES OF CLIENTS AND CATHOLIC FAMILY CENTER

I. CLIENT'S RIGHTS

All clients of Catholic Family Center (CFC) have these rights:

1. **The right of CONFIDENTIALITY:** We consider all information about you to be strictly confidential. This means information about you is **not** discussed by your worker with any person who does not have a professional need to know about it. This includes people who work at CFC, as well as people who work outside the agency.

Information about you can be released only when you (or your parent/legal guardian, if you are a minor) give written permission for CFC to do so. This applies to all types of information, including the use of photographs you might be in. The only situations where CFC is legally required to release certain information **without** your written permission are:

- cases of suspected child/elder abuse or neglect;
- we have reason to believe that you are thinking about harming yourself or someone else; or
- there is a court order that requires us to release information about you.

If any of these situations occur, CFC will inform you about the release of information **if it is legally permissible, and if it is safe to you and others to do so.**

2. The right to **review your case record** with a member of the professional staff.
3. The right to **be involved in developing the plan of services or treatments you will receive.**
4. The right to **refuse specific services or treatments.** When there is a court order that tells you that you **must** receive services, your worker will talk with you about any problems that might occur if you refuse to accept the service or treatment.
5. The right to **file a complaint or grievance** if you have a **serious** concern about a decision made about your case, a CFC service, or a CFC employee or volunteer.
6. The right to **receive services without discrimination** based on age, color, disabling condition, ethnicity, gender marital status, national origin, race, religion, or sexual orientation.
7. The right to **get a referral** to another appropriate community agency if CFC cannot provide the services you need, or if you prefer to go somewhere else (and are not prevented from doing so by a court order).

If you have questions about any of these rights, or the CFC policies related to them, ask to speak with the Director of the department where you are receiving services.

II. CLIENT RESPONSIBILITIES

In addition to their rights, all clients of CFC have the following responsibilities:

1. **Keeping all scheduled appointments.**
2. Canceling any appointment with 24 hours' notice.
3. **Paying all fees as stated in their financial agreement with CFC.** This applies only to clients of services that charge fees. Consistently missing payments or refusing to pay fees may be grounds for terminating service.
4. **Providing all relevant information** needed for their planned services/treatment to their worker.
5. **Cooperating with their worker and plan of services.** Consistent refusal to cooperate with their worker may be grounds for terminating services.
5. **Acting in a socially responsible manner** towards CFC personnel, property, and other clients. Abusive behavior towards others, disruption of the services at any CFC facility, or damage to CFC's (or other's) property may be grounds for termination of services.

III. CATHOLIC FAMILY CENTER'S RIGHTS

Catholic Family Center (CFC) retains the following rights:

1. Where it is proper to do so, the right to **charge a fee** based on a client's ability to pay. CFC maintains and uses a fee schedule that is based on standard rates in the community for similar services. CFC has the right to adjust or waive its fee, based on client need.
2. The right to **bill a client for a missed appointment** that was not cancelled with 24 hours' notice (this applies only to clients who are charged a fee). This right is also stated in the client's financial agreement with CFC.
3. The right to **determine if CFC is the appropriate agency to address the client's needs** based on our resources, capabilities, and mission.
4. The right to **discontinue services if the client does not meet his/her responsibilities.**

IV. CFC RESPONSIBILITIES

Catholic Family Center is responsible for:

1. **Maintaining client confidentiality** at all levels.
2. **Assuring that clients receive the highest possible quality of service.**

3. **Serving all clients with respect and dignity** regardless of age, color, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.
4. **Involving clients (and parents/legal guardians, as appropriate)** in the development of their service/treatment plans.
5. **Offering to place clients on a waiting list** if the needed service/treatment is not immediately available, and **monitoring** waiting lists so clients are served in a timely manner.
6. **Referring clients to another community agency** if CFC cannot provide the needed services, or if the client prefers to be referred.
7. **Providing clients with access to information about CFC policies** on clients' rights and the complaint/grievance procedure.

I have reviewed this Statement with my worker and I understand my rights and responsibilities as a client of CFC. I also understand that CFC has rights, as well as responsibilities towards me.

I understand that CFC routinely compares program enrollment lists from its various programs. I have been told that this is done to identify duplicate enrollments. I understand that this information is used only for this internal purpose so that care may be coordinated and so that CFC can produce accurate statistical reports. My confidentiality is protected throughout this process.

Client Signature

Date

Parent/Guardian Signature

Date

Worker (Witness) Signature

Catholic Family Center

Acknowledgments:

I hereby acknowledge that I received a copy of the agency's **Notice of Privacy Practices**.

Yes: _____ No: _____

I would like to receive a copy of any amended **Notice of Privacy Practices**.

Yes: _____ No: _____

E-mail: _____ or by mail at: _____

I hereby acknowledge that I received a copy of the **Statement of Mutual Rights and Responsibilities of Clients and Catholic Family Center (CFC)**. I have reviewed this Statement with my worker and I understand my rights and responsibilities as a client of CFC. I also understand that CFC has rights, as well as responsibilities toward me.

I understand that CFC routinely compares program enrollment lists from its various programs. I have been told that this is done to identify duplicate enrollments. I understand that this information is used only for this internal purpose so that care may be coordinated and so that CFC can produce accurate statistical reports. My confidentiality is protected throughout this process.

Yes: _____ No: _____

Consent for Treatment, Payment and Operations

I understand that as a condition to my receiving treatment and/or services, Catholic Family Center (CFC) may use or disclose my personally identified information to obtain payment for the services provided, and as necessary for operations of this agency.

Yes: _____ No: _____

Fund Raising and Marketing (Catholic Family Center never sells or trades its mailing lists.)

I consent to Catholic Family Center sending me information about its fund raising efforts.

Yes: _____ No: _____

I consent to Catholic Family Center sending me marketing information.

Yes: _____ No: _____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

Witness: _____ DOB: _____

For Office Use Only:

1 Acknowledgment refused:

Efforts to obtain: _____

Reasons for refusal: _____

Notice of Privacy Practices

Catholic Family Center

THIS NOTICE DESCRIBES HOW PROTECTED 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:

Privacy Officer
(585) 546-7220

Catholic Family Center is required by law to maintain the privacy of your protected information and to provide you with notice of its legal duties and privacy practices with respect to your protected information. This Notice of Privacy Practices describes how we may use and disclose your protected information to carry out treatment, payment or health care activities and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected information. "Protected information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. How Catholic Family Center may Use or Disclose Your Protected Information

Catholic Family Center collects information from you and stores it in a chart and on a computer. This is your record. The record is the property of Catholic Family Center, but the information in the record belongs to you. Catholic Family Center protects the privacy of your protected information. The law permits Catholic Family Center to use or disclose your protected information for the following purposes:

Uses and Disclosures of Protected Information

Uses and Disclosures of Protected Information Based Upon Your Written Consent

Your protected information may be used and disclosed by clinical staff, support staff and others that are involved in your care and treatment for the purpose of providing services to you. Your protected information may also be used and disclosed to pay your insurance bills and to support the operation of Catholic Family Center.

Following are examples of the types of uses and disclosures of your protected information that the agency is permitted to make. These are only some examples that describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected information to provide, coordinate, or manage your treatment and any related services. This includes the coordination or management of your treatment with anyone else you give permission to have access to your records.

For example, we would disclose your protected information, as necessary, to your health insurance provider that pays for service or to a physician from whom you may have been referred.

Payment: Your protected information will be used, as needed, to obtain payment from your insurance coverage. This may include certain activities that your health insurance plan may undertake before it approves or pays for the services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you and undertaking utilization review activities.

Treatment information may be disclosed to the health plan in order to obtain approval for payment of services.

Operations: We may use or disclose your protected information in order to support the business activities of Catholic Family Center. These activities include, but are not limited to, quality assessment activities, training of staff, licensing, accrediting and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your worker. We may also call you by name in the waiting room when your worker is ready to see you.

We will share your protected information with third party “business associates” that perform various activities (e.g. auditing or legal services) for Catholic Family Center. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected information, we will have a written contract that contains terms that will protect the privacy of your protected information.

Uses and Disclosures of Protected Information based upon Your Written Authorization.

Information that would identify you as a person seeking help for a substance abuse problem is protected under a separate set of federal regulations known as “Confidentiality of Alcohol and Drug Abuse Patient Records”, 42 C.F.R. Part 2. Under certain circumstances these regulations will provide your protected information with additional privacy protections beyond those that have already been described.

Catholic Family Center will follow the provisions of 42 CFR Part 2 governing disclosure of protected information. Except for the circumstances described below, we will not disclose protected information to a third party without written permission of the individual or a court order. If a request for disclosure of your record is received, you will be contacted and asked whether you wish to authorize disclosure. If you refuse to authorize disclosure, or it is not possible for us to contact you in person, we will not disclose your information without a court order.

If you do authorize Catholic Family Center to use or disclose your protected information for another purpose, you may revoke your authorization in writing at any time. If you revoke authorization, it will not affect disclosure or use of information that has already occurred.

Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object.

We may use or disclose your protected information in the following situations without your consent or authorization. These situations include:

- Pursuant to court order and subpoena
- Medical personnel in an emergency
- Suspected incidents of child abuse or neglect
- To agencies that provide regulatory authority
- Audit and evaluation activities
- To report crime (or threat of crime) on premises or against program personnel. Information is limited to circumstances, name and address, and last known whereabouts.

2. Your Rights

Following is a statement of your rights with respect to your protected information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected information. This means you may inspect and obtain a copy of protected information about you that is contained in a designated record set for as long as we maintain the protected information. A “designated record set” contains medical and billing record and any other records that your worker and the agency uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records;

- Psychotherapy notes
- Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and personal health information that is subject to law that prohibits access to personal health information.

Depending on the circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected information. This means you may ask us not to use or disclose any part of your protected information for the purposes of treatment, payment or healthcare operations. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We do not have to agree to a requested restriction, but will consider your request. If we agree to the requested restriction, we may not use or disclose your protected information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your worker. You may request a restriction by **submitting a request in writing to your treatment provider.**

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. **Please make this request in writing to your treatment provider.**

You may have the right to amend your protected information. This means you may request an amendment of protected information about you in a chart as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, (585) 546-7220, CFCRochester.org for further information about the complaint process.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at <http://www.hhs.gov/ocr/dregmail.html>

E-mail Informed Consent Form

Catholic Family Center (CFC) on occasion provides clients the opportunity to communicate with their staff providers, other healthcare providers, and administrative services by e-mail. Transmitting confidential client information by e-mail, however, has a number of risks, both general and specific, that clients should consider before using e-mail.

Risk Factors: Among general e-mail risks are the following:

- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
-
- Recipients can forward e-mail messages to other recipients without the original sender's permission or knowledge.
- Users can easily misaddress e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Back up copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.

Among specific client e-mail risks are the following:

- E-mail containing information pertaining to a client's diagnosis and/or treatment must be included in the client's records. Thus, all individuals who have access to the record will have access to the e-mail messages.
- Employees do not have an expectation of privacy in e-mail they send or receive at their place of employment. Thus, clients who send or receive e-mail from their place of employment risk having their employer read their e-mail.
- If employers or others, such as insurance companies, read an employee's e-mail and learn of medical treatment, particularly mental health, sexually transmitted diseases, and/or alcohol and drug abuse information, they may discriminate against the employee/client. For example, they may fire the employee, not promote the employee, deny insurance coverage, and the like. In addition, the employee could suffer social stigma from the disclosure of such information.
- Clients have no way of anticipating how soon CFC and its employees and agent will respond to a particular e-mail. Although CFC and its employees and agents will endeavor to read and respond to e-mail promptly, CFC cannot guarantee that any particular e-mail message will be read and responded to within any particular period of time. Behavioral health and human service providers rarely have time between appointments, consultations, staff meetings, meetings away from facility, and meetings with clients and their families to continually monitor whether they have received e-mail. **Thus, clients should not use e-mail in a medical emergency.**

Conditions for the Use of E-mail

It is the policy of CFC that CFC will make all e-mail messages sent or received that concern the diagnosis or treatment of a client part of that client's record and will treat such e-mail messages with the same degree of confidentiality as afforded other portions of the record. CFC will use reasonable means to protect the security and confidentiality of e-mail information. Because of the risk outlined above, CFC cannot, guarantee the security and confidentiality of e-mail communication.

Thus, clients must consent to the use of e-mail for confidential information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

- All e-mails to or from the client concerning diagnosis and/or treatment will be made a part of the client's record. As a part of the record, other individuals, such as funders, client accounts personnel and the like, and other entities, such as other healthcare providers and insurers, will have access to e-mail messages contained in records.
- CFC may forward e-mail messages within the facility as necessary for diagnosis, treatment, and reimbursement. CFC will not, however, forward e-mail outside the facility without consent of the client or as required by law.

- If the client sends e-mail to CFC, one of its staff members, or an administrative department, CFC will endeavor to read the e-mail promptly and respond promptly, if warranted. However, CFC can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. **Because CFC cannot assure clients that recipients will read e-mail messages promptly, clients must not use e-mail in an emergency.**
- If a client's e-mail requires or invites a response, and the recipient does not respond within a reasonable time, the client is responsible for following up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- Because some medical information is so sensitive that unauthorized disclosure can be very damaging, clients should not use e-mail for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like. Clients should be aware that information concerning mental health or developmental disability; or alcohol and drug abuse has the same sensitivities and risks.
- Because employees do not have a right of privacy in their employer's e-mail system, clients should not use their employer's e-mail system to transmit or receive confidential information.
- CFC cannot guarantee that electronic communications will be private. CFC will take reasonable steps to protect the confidentiality of client e-mail but is not liable for improper disclosure of confidential information not caused by CFC gross negligence or wanton misconduct.
- If the client consents to the use of e-mail, he/she is responsible for informing CFC of any type of information the client does not want to be sent by e-mail.
- Client is responsible for protecting his/her password or other means of access to e-mail sent or received from CFC to protect confidentiality. CFC is not liable for breaches of confidentiality caused by client.
- Any further use of e-mail by the client that discusses diagnoses or treatment by the client constitutes informed consent to the foregoing. **You may withdraw consent to the use of e-mail at any time by e-mail or written communication to CFC, attention: Privacy Officer.**

I, _____ <Client Name> have read and understand the policy on consent to use e-mail as a means of communicating with Catholic Family Center staff. By signing this form, I am giving consent to CFC to communicate with me or the person (s) indicated below via e-mail.

 Person(s) CFC has permission to communicate with regarding my client information via e-mail. (Please print)

 Signature

 Date

 Staff Witness

 Date

Please give one copy to the client and place the original in the client's record.