Multicultural Counseling and Research Center
225 S. Meramec, Suite 203
St. Louis, MO 63105
314-445-5678

Consent for Treatment & Client Information

NAME _____ DATE _____

Mailing Address _____

Home Phone _____ Cell Phone _____ Leave a message? Yes/No

Thank you for choosing MCRC. We realize that starting therapy is a major decision and you may have many questions. This document represents informed consent and an agreement between us. By signing it, you acknowledge that you have received the information necessary to make an informed and voluntary decision to participate in counseling as provided.

- Sessions are 50-55 minutes long unless scheduled otherwise.
- Full fee per session is $_____
- Payment is due at the time services are rendered in the form of cash, personal check, or credit card.

APPOINTMENTS AND CANCELLATIONS
Once an appointment is scheduled, we require 24 hours advanced notice of cancellation. In order for us to keep fees reasonable and accept certain insurance, you must pay for any missed sessions. Insurance companies do not pay for missed sessions.

CONFIDENTIALITY
All communication with your counselor is confidential and will not, except under circumstances explained below, be disclosed to anyone outside of MCRC unless you give written authorization to release information.

LIMITS TO CONFIDENTIALITY
I understand that any Multicultural Counseling and Research Center staff member is required by law to release information to the appropriate agencies in the following specific situations:

- There is a reasonable belief that I may harm myself
- There is a reasonable belief that I may harm someone else
- There is reasonable evidence of the physical or sexual abuse of a minor or elder.
- In addition, a court order may require release of privileged communication.

I hereby acknowledge and consent to counseling treatment and/or assessment for myself, my child or my legal ward as is deemed appropriate by the clinical staff and associates of Multicultural Counseling and Research Center (MCRC). My signature on this form indicates my intent to retain the professional counseling services of Multicultural Counseling and Research Center.

_____Date:_____
Client

_____Date:_____
Guardian or parent signature if client is a minor or legally adjudicated to be incompetent

Witness:_____Date:_____

I acknowledge receipt of a copy of the privacy policies of this office (HIPAA) _____

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NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information "protected health

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Require Your Written Consent. We may use and disclose your PHI with your consent for the following reasons:

B. Certain Uses and Disclosures Do Not Require Your Consent. We may use and disclose your PHI without your consent or authorization for the following reasons:

C. All Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections IIIA, B and C above, we will ask for your written authorization before using or discussing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken an action relying on the authorization).

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI.

B. The Right to Choose How We Send PHI to You.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing.

D. The Right to Get a List of the Disclosures We Have Made.

E. The Right to Correct or Update Your PHI.

F. The Right to Get This Notice by E-Mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue SW, Room 635G, Washington D.C. 20201 (http://dhhs.gov/ocr). We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our 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: Multicultural Counseling and Research Center (MCRC) 225 S. Meramec, Suite 203, St. Louis, MO 314-724-1486.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.