The Center
- FOR COUNSELING & CONSULTATION -
Cultivating Help, Hope, and Healing.

5815 Broadway • Great Bend, KS 67530
800-875-2544 • 620-792-2544 • 620-792-7052 (fax)

REGISTRATION FORM

CLIENT INFORMATION

Last Name:	First Name:	Middle:	☐ Jr. ☐ Sr. ☐ Other_____	Maiden Name:

Sex:	Birth date:	Age:	Social Security Number:	Marital status (check one)
☐ M ☐ F				☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Widow

Have you been seen previously at this office?	If yes, what year and under what name?	E-mail Address:
☐ Yes ☐ No		

Street address:	P.O. Box:

City:	State:	ZIP Code:	County:

Home Phone Number:	Cell Phone Number:	Contact Phone Number:	Work Phone Number:

Referral Source: ☐ Self ☐ Family ☐ DCF Area Office ☐ Social/Community Agency ☐ Court ☐ Other:_____

How did you hear about us? ☐ Magazine ☐ Newspaper ☐ Radio ☐ Other_____ ☐ Kiosk

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic **Education:**(Highest level completed & School)_____ **Veteran** ☐ Yes ☐ No

Race: ☐ Am. Indian/Alaska Native ☐ Asian ☐ Black/African Am. ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Hospitalization (Most Recent): ☐ None ☐ State Mental Health Hospital ☐ Private Psychiatric Hospital ☐ Out of Home Crisis Stabilization ☐ General Hospital Psychiatric Ward ☐ Inpatient Substance Abuse Treatment (excluding detox) ☐ Residential Mental Health Treatment within a state correctional facility

PRIMARY CARE PHYSICIAN

Name:	Phone no.:	Street: City-St, ZIP:

CONTACT PERSON (TO BE NOTIFIED OF APPOINTMENT INFORMATION)

Relationship to Client: ☐ Self (use previous info.) ☐ Parent ☐ Grandparent ☐ Foster Parent ☐ Guardian ☐ Other

Name:	Home Phone no.:	Cell Phone no.:

Street address:	P.O. Box:

City:	State:	ZIP Code:

LEGAL GUARDIAN INFORMATION

Name:	Home Phone no.:	Cell Phone no.:

EMERGENCY-CONTACT INFORMATION

Name:	Home Phone no.:	Cell Phone no.:

FOR BUSINESS OFFICE USE ONLY

Admission Date:		Time:		Therapist:	
Assigned ID #:			Generic ID #:		
PP responsibility:		Discount:		Begin Date:	End Date:

CLIENT INFORMATION

Supplemental Security Income or Social Security Disability Insurance Eligibility: ☐ Not Applicable ☐ Eligible and Receiving Payments ☐ Eligible but not Receiving Payments ☐ Potentially Eligible (case not yet submitted for Determination) ☐ Determined to be Ineligible by Review and Decision ☐ Determination Decision on Appeal

Employment: ☐ Part-time ☐ Full-time ☐ Retired ☐ Unemployed ☐ Not in Labor Force

Employer:	Employer phone no.:	Length of Employment:

ADULT CLIENT (SELECT ONE OPTION FOR EACH CATEGORY)

Current Educational Status: ☐ No Educational Participation ☐ Vocational Educational Involvement ☐ Pre-Educational Explorations ☐ Working on GED ☐ Working on English as Second Language ☐ Basic Educational Skills ☐ Attending Vocational/High School ☐ Attending College (1-6 hrs.) ☐ Attending College (7/more hrs.) ☐ Other_____

Current Residential Arrangement: ☐ Nursing Home ☐ NFMH ☐ Group Home ☐ Boarding Home ☐ Lives w/Relative (heavily dependent) ☐ Lives w/Relatives (largely independent) ☐ Supervised Housing Program ☐ Independent Living ☐ Other ☐ Precariously Housed ☐ Homeless

Current Vocational Status: ☐ No Vocational Activity ☐ Prevocational Activity ☐ Screening and Evaluation of Vocational Interests and Abilities ☐ Active Job Search ☐ Participating in Sheltered Work Program ☐ Employed in Transitional Employment ☐ Volunteer Activity ☐ Care Taker (children or others) ☐ Working less than 30 hrs. per week ☐ Working more than 30 hrs. per week ☐ Other ☐ Retired

CHILDREN/YOUTH CLIENT (SELECT ONE OPTION FOR EACH CATEGORY)

Custody Status: ☐ Child in JJA Custody and out of home placement ☐ Child in JJA Custody and lives at home ☐ Child is under supervision of JJA, but not in their custody ☐ Child is in DCF custody and out of home placement ☐ Child is in DCF custody and lives at home ☐ Child is under DCF supervision, but not in their custody ☐ No JJA or DCF involvement

Foster Care Contractor: ☐ Not Applicable ☐ KCSL (foster care) ☐ The Farm ☐ UMY ☐ KCSL (adoption) ☐ KVC ☐ St. Francis ☐ DCCA

Current Educational Status: ☐ Not Applicable ☐ Institutional Instruction ☐ Residential School ☐ Home-based Instruction f/School District ☐ Special Education ☐ Reg. Classroom w/Special Ed. Services ☐ Regular Classroom ☐ Home Schooling not provided by School District ☐ Not in School (suspended) ☐ Not in School (graduated) ☐ Not in School (working on GED) ☐ Not in School (expelled) ☐ Not in School (drop-out) ☐ Preschool ☐ Other ☐ Alternative Education w/Intensive Psychosocial ☐ Not in School (summer break) ☐ Therapeutic Services for Preschool Children ☐ Enrolled in Post-Secondary Education

Current Residential Setting: ☐ Jail/Detention ☐ State Hospital ☐ Inpatient Psychiatric Unit ☐ Crisis Resolution/Stabilization Unit ☐ Drug/Alcohol Treatment Center ☐ Residential Treatment/Level VI ☐ Group Home (Levels III, IV, V) ☐ Emergency Shelter ☐ Therapeutic Foster Care ☐ Foster Home ☐ Temporarily living w/ Relative or Family Friend ☐ Permanent Home(biological/adoptive) ☐ Independent Living ☐ Homeless

Total Number of Arrests:_____Number of Adjudicated Felonies for crimes:_____Number of Adjudicated Felonies for property crimes:_____Number of Adjudicated Felonies for crimes against persons:__Number of Adjudicated Misdemeanors:_____Number of Law Enforcement Contacts:_____

PRIMARY INSURANCE INFORMATION				
Subscriber's relationship to Client:	☐ Self	☐ Spouse	☐ Child	☐ Other _____
Subscriber's Name (Policy Holder):		Social Security No.:		Birth date:
Street address:			P.O. Box:	
City:	State:	ZIP Code:		Phone no.:
Employer:		Employer phone no.:		
Policy No.:			Group No.:	
Insurance Co. Name:			Effective Date:	
Street address:			P.O. Box:	
City:	State:	ZIP Code:		Phone no.:

SECONDARY INSURANCE INFORMATION				
Subscriber's relationship to Client:	☐ Self	☐ Spouse	☐ Child	☐ Other _____
Subscriber's Name (Policy Holder):		Social Security No.:		Birth date:
Street address:			P.O. Box:	
City:	State:	ZIP Code:		Phone no.:
Employer:		Employer phone no.:		
Policy No.:			Group No.:	
Insurance Co. Name:			Effective Date:	
Street address:			P.O. Box:	
City:	State:	ZIP Code:		Phone no.:

RESPONSIBLE PARTY INFORMATION (PERSON LIABLE FOR PAYMENT)				
Relationship to Client:	☐ Self (use previous info.)	☐ Spouse	☐ Mother-Father	☐ Other _____
Responsible Party Name:		Social Security No.:		Birth date:
Street address:			P.O. Box:	
City:	State:	ZIP Code:		Phone no.:
Employer:		Employer phone no.:		Length of Employment:
Gross Family Annual Income: $		Number of person's supported by this income (must be living in home):		

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SIGNATURE FORM

CONSUMER INFORMATION			
Last Name:	First Name:	Birth date:	SSN:

PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS BEFORE SIGNING.

( ) I have received a copy and understand The Center for Counseling & Consultation's Fee Policy and Client Rights. I understand that Proof of Income must be provided to receive reduced fees.

( ) I have received a copy and understand The Center for Counseling & Consultation's Notice of Information Practices & Notice of Treatment Non Discrimination.

( ) I allow the coordination of care between The Center for Counseling & Consultation and my Primary Care Physician.

( ) Assignment of Insurance Benefits: In the event the client/responsible party or the undersigned is entitled to benefits arising out of any insurance policy covering the client, those benefits are hereby assigned to THE CENTER for application toward the clients account. I authorize the release of any medical information necessary to process the claim and request payment of insurance benefits. I understand that I am financially responsible for any charges not covered by insurance.

(IF THIS FORM IS BEING COMPLETED B A REPRESENTATIVE OF THE CLIENT)
PLEASE INITIAL AND PRINT THE NAME OF THE CLIENT RECEIVING SERVICES BELOW.

( ) I am requesting services for _____

The Center shall not use text or e-mails with you without your consent via this authorization form and, should you to choose to authorize The Center to communicate with you in this fashion, you agree to waive, release, and discharge The Center from any and all responsibilities or liability from unintentional exposure of information communicated via these modes.

☐ Text Message ☐ Email _____ ☐ Voicemail ☐ I prefer NOT to be Contacted in these manners.

Acknowledgement for Photograph

I hereby acknowledge that I have been advised that a photograph will be taken of me for the use of Identification purposes only.

☐ I hereby give my consent for The Center to take my photograph. ☐ I Do Not wish for my photograph to be taken by The Center.

X _____

Date

Type Name of Client/Responsible Party/Guardian

☐ By checking this box you agree that typing your name it will be used in place of your signature.

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PHONE (620) 792-2544 5815 BROADWAY
GREAT BEND, KANSAS 67530

NOTICE OF FEE AND SCHEDULING POLICIES
(Effective March 1, 2018)

Thank you for choosing The Center for Counseling & Consultation. We strive to provide the highest quality and affordable behavioral health care to our patients with compassion and integrity. Please understand that payment of your bill and keeping your scheduled appointment is considered part of your treatment plan. Your clear understanding of the Fee/Payment Policy and Scheduling Policy is important to our Professional Relationship.

Fee and Payment Policy

Full payment is due at the time of service. We make every effort to keep down the cost of your medical care. It is our policy to ask for payment at the time of your visit. The Center participates with most major insurance carriers including Medicare, Medicaid and Blue Cross and Blue Shield. However, it is your responsibility to pay copays, deductibles, and any amount not covered by your insurance at the time treatment is provided. Remember you are responsible for understanding your insurance in regards to what is covered, not covered, limitations, exceptions, waiting periods etc. If you have any questions regarding your coverage, please speak to a member of our office team.

Please be aware that we offer an income based sliding fee schedule if you do not have insurance or you receive services not covered by your insurance company. To be eligible for the sliding fee schedule, you must present proof of income, residency and citizenship to our office team for review and establishment of a reduced fee. Those qualifying for the nominal minimum fee on the sliding schedule are required to provide income verification every 90 days. All other established reduced fees will be reviewed annually.

For your convenience, we accept Cash, Checks (with valid identification), Visa and Mastercard.

Please be further advised that some EAPs and insurance carriers including Medicare only authorize coverage for specific types of providers. Accordingly unless specifically authorized by either our Clinical Director or Medical Director, clients will only be scheduled with authorized providers. In the event a client elects to see a non-covered provider, payment in full is required prior to the scheduling of the non-crisis appointment/service.

Cancellation Policy

Please understand that keeping your scheduled appointment is considered part of your treatment plan and is essential so that we may maintain the availability of quality behavioral health services at an affordable price. In the event that you need to change a scheduled appointment, our office requires 24 hour notification. Please be advised that consecutive no shows or two (2) no shows in a ninety (90) day period will result in the suspension of your ability to be re-schedule for non-crisis services until your scheduling request has been reviewed and authorized by either our Clinical Director or Medical Director.

Outpatient Attendance Agreement

We want to help you succeed in treatment. Your provider is committed to your wellness and recovery and will meet with you on time and be ready to work, talk with you about your diagnosis and treatment, and develop treatment goals with you. Missing scheduled appointments interferes with the effectiveness of treatment and prevents another client from benefitting from that time. You can show your commitment to services by being direct and honest with your provider, using each session to work on your goals, and keeping your appointments. Please read the policy outlined below and sign is you agree to follow this policy.

- Appointments should be cancelled with at least 24 hour notice so that the time slot can be filled.
- After each missed appointment, either by a no-show or a late cancel, the provider will discuss the reasons for the missed appointment with the client to agree upon the remedies to prevent further missed appointments.
- Reoccurring appointments will not be allowed following a no-show or multiple late cancels.
- When a client has 3 no-shows in a 60-day period or 2 consecutive no-shows, all future therapy appointments will be removed and the client will have the option to call when they are ready to come in for therapy to see if their therapist is available that day or within that week; if not, they can try again another day or have the option to attend ongoing skill building group therapy sessions instead of individual therapy.
- If a client no-shows for appointments with medication staff, they will need to MAKE an appointment to get a refill on medications. If they then miss that appointment, they need to make and ATTEND an appointment to get a refill.

Thank you for your consideration. Please talk to our office team if you have any questions or concerns.

I have read the above and fully understand the terms.

_____ _____

Type the name of Client/Responsible Party/Guardian Date

_____

Client #

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NAME: _____ DATE: _____

What brings you here today? ☐ Mental Health Services

Are you currently pregnant? ☐ Yes ☐ No Are you currently breast feeding? ☐ Yes ☐ No

Were you referred by anyone? ☐ Yes (who _____) ☐ No

SYMPTOM CHECKLIST

Please check any symptoms you have struggled with over the past two weeks:

- ☐ Depressed mood
- ☐ Lost interest or pleasure
- ☐ Lack of energy/fatigue
- ☐ Unable to concentrate
- ☐ Suicidal thoughts
- ☐ Aggression toward others
- ☐ Sexual problems
- ☐ Eating problems
- ☐ Alcohol or drug use
- ☐ Marital problems
- ☐ Divorce/separation/affair
- ☐ Relationship problems
- ☐ Work/job problems
- ☐ Gambling problems
- ☐ Legal problems
- ☐ Excessive anxiety or worry
- ☐ Hear/see things others do not
- ☐ Memory problems
- ☐ Significant ongoing pain
- ☐ Academic/school problems
- ☐ Impulsive behaviors
- ☐ Anger/temper
- ☐ Sleep problems
- ☐ Weight gain or loss
- ☐ Decreased need for sleep
- ☐ Pressure to keep talking
- ☐ Racing thoughts
- ☐ Excessive risk taking behavior
- ☐ Panic attacks
- ☐ Excessive fear of situation or object
- ☐ Reoccurring thoughts or impulses
- ☐ Witness/experience threatening event

List Current Medications and Dosage:	Who Prescribed Them
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Fee Policy and Client Rights

A. FEE POLICY

1. The standard fee will be charged to all clients unless the client/responsible party provides proof of household income in order to receive a discount. **There is <u>not</u> a reduced fee option for the following evaluations (Parenting, Psychological, or Substance Abuse).**
2. Proof of income may be a copy of a tax return, paycheck stubs, or signed income statement from employer. If the client/responsible party is on disability or social security, a copy of the electronic deposit or check may serve as proof of income. If client/responsible party is married a copy of spouses income must also be presented.
3. Client/responsible party will be billed monthly.
4. If the client/responsible party does not provide proof of income within the first 30 days of service, the discount will not be retroactive. It will begin as of the date the proof of income is provided.
5. A client/responsible party must make some type of payment each month in order to keep their account current. If a regular payment is not made and/or a payment arrangement completed and signed, the account will go into the collection process. The client/responsible party will be responsible for attorney fees and collection cost in the event there is a default of payment.
6. The collection process is a 90-day process. A statement is mailed at the end of the first month or 30 days. If no payment is received, a reminder is mailed at the end of the second month or 60 days. If no payment is received at the end of 90 days, a letter is mailed informing the client/responsible party that the account will be turned over to collections unless a payment is received.
7. If a client/responsible party is unable to make a payment each month, they need to meet with the Business Office to make payment arrangements and sign a payment agreement.
8. If a client/responsible party has been sent to collection twice and is still not making payments, the client/responsible party will have to pay cash in advance for each visit in order to be seen.

B. CLIENT RIGHTS (*this is in addition to the <u>Notice of Information Practices</u>*)

1. Any time you wish to discontinue treatment or to terminate the diagnostic procedure, you have the freedom to do so.
2. The client has the right to be treated with dignity and respect, and not to be subjected to any verbal or physical abuse or exploitation.
3. The client has the right not to be subjected to the use of any type of treatment, technique, intervention, or practice, including the use of restraint or seclusion, done solely as a means of coercion, discipline, retaliation, or for convenience of the staff or any volunteer or contractor.
4. The client has the right to receive treatment in the least restrictive, most appropriate manner.
5. The client has the right to an explanation of the potential benefits and any known side effects or other risks associated with all medications that are prescribed.
6. The client has the right to an explanation of the potential benefits and any known adverse consequences or risks associated with any type of treatment.
7. The client has the right to be provided with information about other clinically appropriate medications and alternative treatments, even if these medications or treatments are not the recommended choice of that client's treating professional.
8. A client voluntarily receiving treatment has the right to refuse any treatments or medications to which that client has not consented, in compliance with the client's rights.
9. A client involuntarily receiving treatment pursuant to any court order has the right to be informed that there may be consequences to the client if the client fails or refuses to comply with the provisions of the treatment plan or to take any prescribed medication.
10. The client has the right to refuse to take any experimental medication or to participate in any experimental treatment or research project, and the right not to be forced or subjected to this medication or treatment without the client's knowledge and express consent, given in compliance with the client's rights, or as consented to by the client's guardian when the guardian has the proper authority to consent to this medication or treatment on the client's behalf.
11. The client has the right to actively participate in the development of an individual treatment plan, including the right to request changes in the treatment services being provided to the client, or to request that other staff members be assigned to provide these services to the client.
12. The client has the right to receive treatment or other services from a licensee in conjunction with treatment or other services obtained from other licensed mental health professional or providers who are not affiliated with or employed by that licensee, subject only to any written conditions that the licensee may establish only to ensure coordination of treatment or any services.
13. The client has the right to be accompanied or represented by an individual of the client's own choice during all contacts with the licensee. This right shall be subject to denial only upon determination by professional staff that the accompaniment or representative would compromise either that client's rights of confidentiality, or the rights of other individuals, would significantly interfere with that client's treatment, or that of other individuals, or would be unduly disruptive to the licensee's operations.
14. The client has the right to see and review the clinical record maintained on that client, unless the executive director of the licensee has determined that specific portions of the record should not be disclosed. This determination shall be accompanied by written statement placed within the clinical record required by K.A.R. 30-60-46, explaining why disclosure of the portion of the record at this time would be injurious to the welfare of that client or to others closely associated with that client. The client has the right to receive a copy of his or her medical records and to request they be amended or corrected as specified in 45CFR part 164.
15. The client has the right to have staff refrain from disclosing to anyone the fact that the client has previously received or is currently receiving any type of mental health treatment or services, or from disclosing or delivering to anyone any information or material that the client has disclosed or provided to any staff member of the licensee during any process of diagnosis or treatment. This right shall automatically be claimed on behalf of the client by the licensee's staff unless that client expressly waives the privilege, in writing, or unless staff are required to do so by law or a proper court order.
16. The client has the right to exercise the client's rights by substitute means, including the use of advance directives, a living will, a durable power of attorney for health care decisions, or through springing powers provided for within a guardianship; and the right of the client to at any time make a complaint in accordance with K.A.R. 30-60-51 concerning a violation of any of the rights listed in this regulation or concerning any other matter, and the right to be informed of the procedures and process for making such a complaint.

Fee Policy and Client Rights (Continued)

17. The client has the right to express a concern or complaint regarding any Center staff member, requirement, operation or service.
18. The client has the right to request a clinician who understands his/her language and culture.
19. The client has the right to receive needed services at convenient times and places; to obtain access to services within the specified access standards.
20. Each client is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the client is treated by The Center (or Kansas Health Solutions as applicable to clients whose services are funded by Medicaid).

Notice of Information Practices

The Center maintains client records consisting of personal, financial, and medical information which is used for diagnosis, treatment, and healthcare operations. The Health Insurance Portability and Accountability Act establishes privacy rules that govern the use and disclosure of this information as do various state statutes. The Center is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. 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.

Uses and Disclosures of Health Information: Most uses and disclosures of information require the written authorization of the client, which clients may revoke later in writing once given except as required by law. However some uses and disclosures can occur both in routine and non-routine ways in the process of providing treatment, payment, and healthcare operations without the need of written authorization. Examples of such routine uses and disclosures for treatment include the sharing of clinical information among multiple providers of the Center working with you or the provision of treatment-related mental health information to providers treating you outside of the Center as needed. Non-routine examples could include in certain circumstances and using professional judgment the disclosure of selected protected information to family members or others involved in your care unless you object, to medical personnel when a medical condition poses an immediate threat to the health of the client and/or emergency intervention is warranted, or to officers of the court when treatment is required by the court or health information disclosed to appropriate agencies as required by law. Examples of routine uses and disclosures for payment include the provision of information relative to diagnoses, dates, and types of treatment provided to third-party payers, (insurance companies and governmental funding agencies), with the exception of substance use treatment. While examples of routine uses and disclosures for healthcare operations could include review of protected health information for the purposes of utilization management and corporate compliance as well as state licensing activities, non-routine uses and disclosures may include accessing your protected health information for risk management activities.

Your Rights: Although health records about you are the Center's property, you have certain rights with regard to the information contained therein including the following:

1. You have the right to obtain a copy of this notice of information practices. While the notice is available electronically on the Center website at www.thecentergb.org, a written copy is provided to you upon admission.

2. You have the right to inspect and obtain a copy of health information about you upon written request. That right, however, is not absolute as the Center can deny access if access might cause harm to the client or another individual. Should that situation occur, the Center will inform you of the reason for denying access and how to seek review of that decision. The reviewable grounds for denial include:

The access is reasonably likely to endanger the life or physical safety of the individual or another person as determined by a qualified mental health professional.

The health information makes reference to another person and such information is likely to cause substantial harm to the other person as determined by a qualified mental health professional.

For these reviewable grounds, the executive director will review the decision of the provider denying access and provide the client a written response within 60 days.

If you request an electronic copy of protected health information that is maintained electronically in record sets, the Center will provide you access to the information in electronic form and format if it is readily producible, or, if not, in a readable electronic form and format agreed to by you and the Center.

You have the right to request a correction or amendment to health information about you. We do not have to grant that request if the record was not created by the Center. You would have to request correction or amendment from the agency who created that record. If they change the record, we will file the change in our record. We do not have to grant the request if the record is accurate and complete. If your request for correction or amendment is denied, the Center will inform you of the reason for denial. If request is accepted, the change will be made to the record and distributed to whomever you designate as needing the information.

You have the right to request restriction on uses and disclosures of health information about you for treatment, payment, and healthcare operations, though we do not have to agree to the request. If granted, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means and, if the method of communication is reasonable, we must grant the request.

You may request the Center not to disclose health information about you to a health plan if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law and the protected health information pertains solely to a health care item or service for which you or person other than the health plan on behalf of the individual has paid the Center in full.

You have the right to obtain an accounting of uses and disclosures other than those for treatment, payment and healthcare operations.

The Center is required to abide by the terms of this notice as currently in effect. We reserve the right to change our information practices and therefore the terms of this notice. Should we change our information practices, those changes will be reflected in a revised notice which would be posted on our website and available at all office locations which you have a right to request.

If you have any questions about this policy or related matters, please contact the Center privacy officer or the executive director at 5815 Broadway, Great Bend, (620-792-2544). If you believe your privacy rights have been violated, you can file a complaint with the Center for Counseling and Consultation privacy officer, or executive director or with the Office for Civil Rights, US Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509 F, HHH Bldg., Washington, D.C.

Date implemented: March 13, 2003, (revised March 20, 2013 and July 25, 2016)

Treatment non-discrimination

The Center for Counseling and Consultation complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. It is the policy of the Center to provide free aids and/or services to people with disabilities to communicate effectively with the Center such as qualifies sign language interpreters or written information provided in other formats. For individuals seeking services with the Center with limited English proficiency, the Center shall provide free language services such as qualified interpreters and information written in other languages. Access to these aids is generally managed by the reception staff of the Center. Notice of this policy will be distributed to clients in their primary language at intake.

The Center's quality improvement director shall oversee the Center's compliance with these expectations and its adherence to Section 1557 of the Affordable Care Act. Should an individual believe that the Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age disability, or sex, a grievance may be filed with the quality improvement director who shall investigate that grievance as appropriate with a response made to the aggrieved individual as soon as practicable.

Trataminento no Discrimination

El Centro de asesoraminento y consulta con las leyes federales de derechos civiles applicable y no discina por motivos de raza, color, origen nacional, edad, discapacidad o sexo. El Centro no excluye a las personas ni las trata de manera diferent debido a su raza, color, origen nacional, edad, discapacidad o sexo. La politica de El Centro es proporciorar asistencia y/o servicios gratis a personas con discapacidades para comunicarse efectivamente con El Centro, como interpretes cualificados de laenguaje de sensas o informacion escrita provista en otros formas. El personal de recepcion del Centro generalmente adminintra el access a estas aydas. El aviso de esta politica se ditribuia a los clientensen su idioma principal en la admission.

El Director de mejora de la calidad de los centros supervisara el cumplimineto por parte del Dentro de estas expectativas y su cumplimiento de la seccion 1557 de la Ley de Asistencia Asequible. Si una persona cree que el centro no ha brindado estos servicios o ha sido discriminado de otra manera por motivos de raza, color, origen nacional, edad, descapacidad o sexo, puede presenter una queja ante ante el director de mejoramiento de calidad, quien investigara esa situacion, queja segun corresponda, con una respuesta hecha a la persona agraviada tan pronto como sea possible.

Consent for Modes of Communication

You have the right to request that The Center communicate with you in alternative ways, some of which entail greater security risks than others. Unencrypted exchange of information via email or texts for instance is less secure. Additionally, of course, some forms of communication outside of direct contact with staff in The Center offices do entail some risk that unauthorized individuals may view or overhear the information. You should keep in mind that use of electronic media as a form of communication and accessing care may not be as complete as face-to-face services. The Center shall not use texts or e-mails with you in this fashion, you agree to waive, release, and discharge The Center from any and all responsibilities or liability from unintentional exposure of information communicated via these modes.