The Clinic at SaintA Referral Checklist

In order to provide services to our clients promptly please ensure that all of the items are submitted with the referral. Referrals will not be processed until these documents are received.

Return the referral to:
SaintA Inc., The Clinic at SaintA
8901 W. Capitol Drive
Milwaukee, Wisconsin, 53222

clinic@sainta.org 414-463-1880 Fax: 414-463-2770

All of these forms can be found on the S:Drive *S:\Agency General Information\The Clinic At Saint A*

☐ Referral Form

☐ Release(s) of Information- *must be signed by a legal parent/guardian*; *make sure forms are completely filled out and make extra copies as needed*

* Release for SaintA Staff
* Release for Caregiver
* Release for School (optional)
* Release for Support Services Provider such as crisis workers or mentors (optional)

☐ Consent for Admission

☐ Confidentiality Policy and Signature

☐ Grievance Policy with Parental Rights and Signature Form

☐ HIPPA Notice (remains with signing adult)

☐ HIPPA Notice Signature

☐ Information for Clients (2 copies: one copy should remain with client and the other should be signed)

☐ Telehealth Consent

Email/Send the following documents with the referral:

☐ Most recent legal document (TPC, Dispositional or Permanency Plan Order)-if applicable

☐ Most recent Care4Kids Care Plan or Health Summary Plan-if applicable

☐ Individual Education Plan (IEP)- if applicable

☐ Psychological Evaluation- if applicable

☐ Applicable Funding Source (i.e. Insurance, private pay, MOU, CCS)

☐ Current recovery goals or Individual Service Plan (ISP) if applicable for CCS/CLTS/WRAP Clients

CLIENT INFORMATION

Name of Client: **DOB:** **Age**:

Insurance Carrier:

Gender: ☐Female ☐ Male ☐ Transgender FTM ☐Transgender MTF ☐Other:

Race: ☐ African-American/Black ☐Asian ☐ Caucasian/White ☐Other:
☐Native American/Alaska Native ☐ Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino ☐ Yes ☐ No **Primary Language:** ☐ English
☐ Spanish
☐ Other:

Religious/spiritual affiliations, please specify:
Does the client have a disability? ☐ No ☐ Yes; accommodations needed:

School/Day Care Name: **Teacher Name**:
Address: **Phone**:
Teacher Email:

Biological Parents/Guardian(s) Name:

All consents will need to be signed by a parent/guardian
Phone:
Phone:

REFERRAL SOURCE

Date of Referral:

Name of Person Completing Form:
Role in supporting youth:
Phone:
Email:
Work Address (for referral source):

Case Manager (if different than referral source):
Phone:
Email:

PLACEMENT INFORMATION (If adult client, personal info here)

Parent/Caregiver Name(s):
Phone:
Email:
Address (where youth resides):

What other information should we know about the Placement Provider?

Is this a TFC Provider through SaintA? ☐ No ☐ Yes; TFC Specialist:

SERVICE(S) BEING REQUESTED:

☐ Therapy; Individual/Family	☐ NMT/Clinical Assessment
☐ Occupational Therapy Assessment/Services	☐ Caregiver Challenge Estimator
☐ Clinical Consultation	☐ Infant Mental Health Specialist Services

Provide a brief description of the primary reasons for requesting clinical services:

Describe plan for client transportation for services obtained on SaintA's campus:

***TO BE COMPLETED BY SAINTA CHILD WELFARE STAFF ONLY:** **Provide the rankings for each of the 7 Essential Ingredients from the 7ei Staffing Protocol:** (0-4 ranking)

Prevalence:	Impact:	Perspective Shift:
Regulation:	Relationship:	Reason To Be:
Caregiver Capacity:		

Approval of Program Supervisor: ☐ **Yes** ☐ **No; Signature:** _____

Approval of Program Director: ☐ **Yes** ☐ **No; Signature:** _____

The following page is the Authorization for Release of Information and Records. There will likely be multiple releases that require signatures, therefore, please make **multiple** copies of this form as needed.

☐ Release(s) of Information- *must be signed by a legal parent/guardian*; *make sure forms are completely filled out and make extra copies as needed*

* Release for SaintA Staff
* Release for Caregiver
* Release for School (optional)
* Release for Support Services Provider such as crisis workers or mentors (optional)

SaintA, Inc.
The Clinic at SaintA
8901 W. Capitol Drive
Milwaukee, WI 53222
(414) 463-1880

AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

I, _____ (parent or guardian) authorize for release of information for _____ (child), Date of Birth _____ .

(Check one) _____ Release To _____ Obtain From _____ Exchange information

The Clinic at SaintA
8901 W. Capitol Drive
Milwaukee, WI 53222
(414) 463-1880

Agency/Professional

_____
Address

_____
City, State Zip

_____
Phone

I understand that the information may include diagnosis, prognosis, and/or treatment for physical, mental disorder, developmental disabilities, alcohol/drug abuse, or HIV results (excludes psychotherapy notes as defined in 45 CFR 164.501)

(Indicate dates) _____Release Format: _____Verbal _____ Written

_____ Letter/Treatment Summary _____ Psychosocial History _____ Discharge Summary

_____ Therapy Progress Reports _____ Psychiatric/ Psychological Evaluations _____ Prescriptions/Medications

_____ Academic Progress Reports _____Alcohol/Drug Abuse _____ Physical Examination

Other (be specific) _____

Purpose or need for information: _____

This authorization will expire in one year from date of signature unless otherwise specified: _____

Patient Rights Pertaining to this Authorization:
RIGHT TO REVOKE THIS AUTHORIZATION: I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated and initiated above.

RIGHT TO RECEVE A COPY OF THIS AUTHORIZATION: I understand that I have a right to receive a copy of this authorization.

RIGHT TO KNOW POTENTIAL FOR RE-DISCLOSURE: I understand that the health information disclosed as a result of this authorization may no longer be protected by federal privacy standards and my health information might be re-disclosed without my authorization.

RIGHT TO RECEIVE A COPY OF RECORDS TO BE RELEASED: The patient who is the subject of the records covered by this authorization, in most cases, has the right to inspect and receive a copy of the material to be disclosed pursuant to this consent form. This authorization form is intended to be in conformance with Section 51.30(4)(d), Wisconsin Statutes and Sections HFS 92.03(3)(d) and 92.06, Wisconsin Administrative codes.

AODA RECORDS: Whenever records or communications concern alcohol and drug abuse (AODA), the release of such records will be in accordance with and under protection of 42 CFR, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records, which state: AODA treatment records which have been discloses are protect4ed by Federal Laws. Federal Regulation (42CFR Part 2) prohibits you from making any further disclosure without specific written consent, conforming to 2.31 of these regulations, of the person to whom these records pertain. The general authorization for the release of medical or other information is not sufficient for this purpose.

RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION: I understand that I am under no obligation to sign this form and that treatment, payment, enrollment in health plan, or eligibility for health care benefits may not be contingent on my signing this authorization.

I authorize the release of copies of any medical treatment records accumulated after my signature through the expiration date of this consent form.

Signature of Subject Individual: _____ Date: _____

_____ Date: _____
Signature of Person Legally Authorized to Consent for the Above Individual (relationship)

Signature of Clinician: _____ Date: _____

SaintA

Telehealth Informed Consent

Introduction:

Please read this document thoroughly and completely.

You have the right, as a Client, to be informed about your condition and the recommended treatment to be used so that you may decide whether to proceed after knowing the recommendations. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the treatment.

I voluntarily request my therapist, and such associates, technical assistants and other outpatient therapy care providers as they may deem necessary for treatment.

I understand that the following treatment recommendations are planned for me and I voluntarily consent and authorize these treatments.

I understand that my therapist may discover other or different diagnosis which require additional or different treatment than those planned. I authorize my therapist, and such associates, technical assistants and other outpatient therapy care providers to provide such other treatments which are advisable in their professional judgment.

To better serve the needs of our community, health care services are now available by interactive video communications and the electronic exchange of information (e.g., Client outpatient therapy records, live two-way audit and video, outpatient therapy device output, etc.). This process is referred to as "telehealth."

Telehealth is expected to improve access to outpatient therapy care by enabling a Client to remain at a remote site while the provider obtains test results and consults from therapists at distant sites. Telehealth may also offer more efficient outpatient therapy evaluation and management, particularly when obtaining the expertise of a distant specialist.

Telehealth involves the use of electronic communications to enable therapists and other healthcare providers at different locations to share Client outpatient therapy information for the purpose of delivering convenient, efficient and effective Client care. The telehealth technology systems incorporate network and software security protocols to protect the confidentiality of Client information and imaging data. In addition, the telehealth technology includes physical, technical and administrative safeguards intended to secure and ensure the integrity of Client information.

Prior to rendering services via telehealth, you should visit with your provider face-to-face for an in-person evaluation.

While the use of telehealth technology is intended to expedite the delivery of high-quality care in a convenient and effective manner, there are potential risks associated with telehealth. These risks may include, but are not limited to, the following:

1. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate outpatient therapy decision making by the on-site or distant-site provider;
2. Technical deficiencies or failures may delay treatment;
3. Transmission or storage of Client's outpatient therapy information could be interrupted, accessed or intercepted by an unauthorized person;
4. A lack of access to the Client's complete outpatient therapy record may result in other judgment errors; or
5. It may become apparent that the telehealth technology cannot provide adequate clinical information during the procedure. If this occurs, the provider must inform the Client prior to the conclusion of the live telehealth interaction and counsel the Client regarding the need for the Client to obtain an additional in-person evaluation with an appropriate provider.

Necessity of In-Person Evaluation:

If it becomes clear that the telehealth modality is unable to provide all pertinent clinical information during a particular telehealth encounter, the Treatment Provider must make it known to the Client prior to the conclusion of the live telehealth encounter. The Treatment Provider must also counsel the Client prior to the conclusion of the live telehealth encounter regarding the need for the Client to obtain an additional in-person outpatient therapy evaluation reasonably able to meet the Client's needs.

By signing this form, I understand the following:

- I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time without affecting my right to future care or treatment.
- The laws that protect privacy and the confidentiality of outpatient therapy information also apply to telehealth. The information disclosed by me during the course of my treatment is generally confidential, but there are mandatory and permissive exceptions to confidentiality.

- The dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my consent.
- I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may obtain copies of such information for a reasonable fee.
- Telehealth is one of a variety of modalities for the provision of outpatient therapy care that may be available to me.
- I may refuse to participate in a telehealth interaction and ask my provider about alternative methods of care.
- Telehealth may involve my provider's electronic transmission of my personal health information to distant-site providers.
- It is my duty to inform my provider of other electronic interactions or telehealth interactions involving my health that I may have with other health care providers.
- If my provider believes I would be better served by another form of service (e.g. face-to-face), I will be referred to another provider in my area who can provide the necessary care.
- In the event of an adverse reaction to treatment or an inability to communicate as a result of a technological or equipment failure, I agree that I will seek follow-up care or assistance at the recommendation of my provider.
- I understand that no warranty or guarantee has been made to me with regard to any result or cure.
- I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.
- I certify this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.
- I have read and understand the information provided above regarding telehealth. I understand that I have the opportunity to discuss the telehealth, including, without limitation, the risks and benefits involved, with my provider or such associates, consultants or other allied health professionals as may be designated. I hereby give my informed consent for the use of telehealth in my outpatient therapy care.
- I hereby authorize my provider and its employees, agents and independent contractors, to use telehealth in the course of my diagnosis and treatment.

By signing this consent form, you agree to:

- Authorize SaintA to share your information electronically with other healthcare provider organizations involved with your care, in accordance with all federal and state privacy and security requirements.

You may elect to withdraw by notifying us in writing and we will request that you sign a termination form.

I hereby permit SaintA to bill for services provided to me and I agree to be responsible for copayments and deductibles.

Email Communications Consent:

I understand that e-mail is a convenience and not appropriate for emergencies or time-sensitive issues. Additionally, I understand that the security and privacy of e-mail cannot be guaranteed. Further, I understand that e-mail should not be used to transmit highly sensitive or personal information.

With regard to my protected health information, I understand that SaintA can send unencrypted emails ONLY if I am advised of the risks. I understand SaintA is not responsible for information lost due to technical failures.

I understand that all of the information contained in and or attached to electronic messages is privileged and confidential and is covered by the Electronic Communications Privacy Act, 18 U.S.C. § 2510-2521.

I consent to e-mail communication with SaintA.

Financial Responsibility

I agree to pay SaintA any and all charges for this telehealth appointment not covered by my health insurance.

_____

Client Name

_____

Responsible Party Name if child is a minor

_____ _____

Client Signature / Responsible Party Signature (if Client is a minor) Date Signed

Notice of Privacy Practices

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Receive Access To This Information.

Please Review It Carefully.

Our Commitment To You

SaintA is committed to maintaining the privacy of your health information. During your treatment with us, physicians, nurses, and other personnel may collect information about your health history and your current health status. This Notice explains how that information, called "Protected Health Information" may be used and disclosed to others. The terms of this Notice apply to health information produced or obtained by SaintA.

Our Legal Duties

The HIPAA Privacy Law requires us to provide this Notice to you regarding our privacy practices, our legal duties to protect your private information and your rights concerning health information about you. We are required to follow the privacy practices described in this Notice whenever we use or disclose your protected health information (PHI). Other companies or persons that perform services on our behalf, called Business Associates, must also protect the privacy of your information. Business Associates are not allowed to release your information to anyone else unless specifically permitted by law. There may be other state and federal laws, which provide additional protections related to communicable disease, mental health, substance or alcohol abuse, or other health conditions.

Your Health Information May Be Used And Disclosed

The HIPAA Privacy Law permits SaintA to make uses and disclosures of your health information for purposes of treatment, payment and health care operations.

- **Treatment:** We will use and may share health information about you for your health care and treatments. For example, a nurse or medical assistant will obtain treatment information about you and record it in a medical record. Alternatively, one of our physicians may use information about you for a consultation with, or a referral to, another physician to diagnose your illness and determine which treatment option, such as surgery or medication, will best address your health needs. Except in emergency circumstances, we will make a "good faith effort" to get your permission prior to making disclosures outside SaintA for treatment purposes.
- **Payment:** We may use and disclose health information about you to obtain payment for the care and services that we have provided to you. For example, we may need to provide your health plan provider with information about you, your diagnosis, and the treatment provided to you at SaintA so that your health insurer will pay us, or reimburse you, for the treatment. We may also contact your health insurance to obtain prior approval about a potential treatment.
- **Health Care Operations:** We may use and share health information about you for SaintA's health care operations, which include planning, management, quality assessment, and improvement activities for the treatments that we deliver. For example, we may use your health information to evaluate the skills of our physicians, nurses, and other health care providers in caring for you. We also may use your information to review quality and health outcomes. We will obtain your written permission before making disclosures to others outside SaintA for health care operations purposes.
- **Appointment Reminders:** We may use and disclose PHI to contact you for appointment reminders and to communicate necessary information about your appointment.
- **Health-Related Benefits, Services and Treatment Alternatives:** We may also contact you about new or alternative treatments or other health care services. For example, we may offer to mail to you newsletters, coupons, or announcements.
- **People Assisting in Your Care:** In certain limited situations, SaintA may disclose essential health information to people such as family members, relatives, or close friends who are helping care for you or helping you pay your health care bills. We will disclose information to them only if these people need to know the information to help you. For example, we may provide limited information to a family member so that they may pick up a prescription for you. Generally, we will ask you prior to making disclosures if you agree to such disclosures. If you are unable to make health-related decisions or it is an emergency, SaintA will determine if it would be in your best interest to disclose pertinent health information about you to the people assisting in your care.

- **Research:** Federal law permits SaintA to use or disclose health information about you for research purposes, if the research is reviewed and approved by an Institutional Review Board to protect the privacy of your health information before the study begins. We may disclose your information if we have your written authorization to do so. In some instances, researchers may be allowed to use information about you in a restricted way to determine whether the potential study participants are appropriate. We will make a "good faith effort" to acquire your permission or rejection to participate in any research study prior to releasing any protected information about you.
- **As Required by Law:** We must disclose health information about you if federal, state, or local law requires us.
- **Serious Threat to Health or Safety:** Consistent with applicable laws, we may disclose your PHI if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Public Health Risks:** As authorized by law, we may disclose health information about you to public health or legal authorities whose official responsibilities generally include the following:
  - To prevent or control disease, injury or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Organ and Tissue Donation:** Consistent with applicable law, we may release your health information to organ procurement organizations or others engaged in the transplantation of organs to enable a possible transplant.
- **Specialized Government Functions:** If you are a member of the military or a veteran, we will disclose health information about you as required by command authorities; or if you give us your written permission. We may also disclose your health information for other specialized government functions such as national security or intelligence activities.
- **Employers:** We may release health information to your employer if we provide health treatment to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will provide you with written notice of such information disclosure. Any other disclosures to your employer will be made only if you sign a specific authorization for the release of that information.
- **Health Oversight Activities:** We must disclose health information to a health oversight agency for activities that are required by federal, state or local law. Oversight activities include investigations, inspections, industry licensures, and government audits. These activities are necessary to enable government agencies to monitor various health care systems, government programs, and industry compliance with civil rights laws. Most states require that identifying information about you, such as your social security number, be removed from information releases for health oversight purposes, unless you have provided written permission for the disclosure.
- **Lawsuits and Disputes:** If you are involved in a lawsuit, dispute, or other judicial proceeding, we may disclose health information about you in response to a court order or subpoena, other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may disclose your health information to a law enforcement official if required or allowed by law, such as for gunshot wounds and some burns. We may also disclose information about you to law enforcement that is not a part of your health record for the following reasons:
  - To identify or locate a suspect, fugitive, material witness, victim of a crime, or missing person

- About a death we believe may be the result of criminal conduct
- About criminal conduct at our location
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Correctional Facilities:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official only as required by law or with your written permission. We may release your health information for your health and safety, for the health and safety of others, or for the safety and security of the correctional institution.
- **Coroners, Medical Examiners, and Funeral Directors:** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release your PHI to a funeral director, as necessary, to carry out his/her duties.
- **Required by HIPAA Law:** The Secretary of the Department of Health and Human Services (HHS) may investigate privacy violations. If your health information is requested as part of an investigation, we must share your information with HHS.

Situations In Which Your Health Information May Be Disclosed With Your Written Consent

For any purpose other than the ones described above, we may only use or share your health information when you give us your written authorization to do so. For example, you will need to sign an authorization form before we can send your health information to your life insurance company. You may revoke an authorization at any time.

- **Marketing:** We must also obtain your written authorization before using your health information to send you any marketing materials. The only exceptions to this requirement are that:
  - We can provide you with marketing materials in a face-to-face encounter or a promotional gift of very small value, if we so choose
  - We may communicate with you about products or services relating to your treatment, to coordinate or manage your care, or provide you with information about different treatments, providers or care settings.
- **Highly Confidential Information:** Federal and state law requires special privacy protections for certain "Highly Confidential Information" about you, including any part of your health information that is about:
  - Child abuse and neglect
  - Domestic abuse of an adult with a disability
  - Mental illness or developmental disability treatment or services
  - Alcohol or drug dependency diagnosis, treatment, or referral
  - HIV/AIDS testing, diagnosis, or treatment
  - Sexually transmitted disease
  - Sexual assault
  - Genetic testing
  - In Vitro Fertilization (IVF)
  - Information maintained in psychotherapy notes

  Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

Your Rights Regarding Health Information We Maintain About You

- **Right to Inspect and Copy**: You have the right to inspect and receive a copy of your PHI. A request to inspect your records may be made to your therapist or to the For PHI in a designated record set that is maintained in an electronic format, you can request an electronic copy of such information. There may be a charge for copies of your PHI.

- **Right to Request Amendment:** If you believe that any health information we have about you is incorrect or incomplete, you have the right to ask us to change the information, for as long as SaintA maintains the information. To request an amendment to your health information, your request must be in writing, signed, and submitted to SaintA. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be maintained with your records. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- **Right to Request Restrictions on Use and Disclosure:** You have the right to request a restriction or limitation on certain uses and disclosures of your health information.
  To request restrictions, you must make your request in writing to SaintA. In your request, you must tell us:
  - What information you wish to limit
  - Whether you wish to limit our use, disclosure, or both
  - To whom you want the limits to apply – for example, if you want to prohibit disclosures for insurance payment, health care operations, for disaster relief purposes, to persons involved in your care, or to your spouse.

  You or your personal representative must sign it.

  We are not required to agree to your request, but we will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction.
- **Right to an Accounting of Disclosures:** With some exceptions, you have the right to receive an accounting of certain disclosures of your PHI. Your accounting request must be in writing and signed by you or your personal representative and submitted to SaintA. Your request must specify the time in which the disclosures were made. These disclosures may not go back further than six years from the date of the request.
- **Right to Request Alternate Communications:** You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box. *You must submit your request in writing to The Clinic at SaintA.* We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to Receive a Copy of this Notice:** You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.
- **Right to Cancel Authorization to Use or Disclose:** Other uses and disclosures of your health information not covered by this Notice or the laws that govern us will be made only with your written authorization. You have the right to revoke your authorization in writing at any time, and we will discontinue future uses and disclosures of your health information for the reasons covered by your authorization. We are unable to take back any disclosures that were already made with your authorization, and we are required to retain the records of the care that we provided to you.

For further information: If you have questions, or would like additional information, you may contact the HIPAA Compliance Officer at SaintA

To File a Complaint: You may submit any complaints with respect to violations of your privacy rights to SaintA. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services if you feel that your rights have been violated. There will be no retaliation from SaintA for making a complaint.

Changes to this Notice: If we make a material change to this Notice, we will provide a revised Notice available at our reception desk or on our website.

Contact Information: Unless otherwise specified, to exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact the HIPAA Compliance Officer, Josh Lorenz at 414-465-1315 or jlorenz@sainta.org.

Effective Date: This Notice is effective as of June 1, 2018.

Receipt of Notice of Privacy Practices

Notice to patient:

We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. By signing below, you acknowledge that you have received our Notice of Privacy Practices.

_____

Patient's name | Patient's Date of Birth

_____

Personal Representative name | Relationship to Patient

_____

Signature | Date

For Office Use Only

In the case that written acknowledgement could not be obtained, please select reason below.

___ Patient/Personal Representative refused to sign.

___ Patient/Personal Representative was unable to sign.

___ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

___ Other reason (please specify):_____

_____

_____

Signature of Workforce Member Completing Form | Date

SaintA
Client Rights and Grievance Policy

Policy Statement:

All children, parents and guardians have the right to file a grievance expressing dissatisfaction with treatment received, disposition of a consequence and/or dissatisfaction with services offered. Suggestions for changes in policy are also dealt with through grievance procedures.

Procedure:

Before using the grievance procedure, clients/parents/guardians are encouraged to discuss perceived problems with staff. If the problem cannot be resolved at this level, then the following procedure is to be followed:

1. The complainant contacts the Director of Quality Outcomes to report his/her complaint (8901 W. Capitol Dr. Milwaukee, WI 53222 800-840-1880) Upon enrollment into a program, a client/parent/guardian is given a copy of the grievance policy and procedures along with a copy of the grievance form. Additional copies of the procedure and form are provided to the client/parent/guardian upon need. However, a client or parent/guardian receiving services from any program may choose to file a grievance using SaintA,'s grievance procedure independent or as an augmentation to any other state or contracted procedures.

2. If complainant is a minor, legal guardians are informed of the nature of the complaint and the process for resolution. A copy of the complaint will also be placed in the client's file. This is done within 24 hours of the initial complaint.

3. Complainant must fill out the "nature of grievance" section on the Client Grievance Form. If the complainant requires assistance in completing this form, the Director of Quality Outcomes will provide assistance as necessary.

4. Within 48 hours of writing of "Nature of Complaint" a meeting is held between the complainant and the director/coordinator of the program in which the problem occurred. The director/coordinator of the program provides a typed summary of the meeting to the Director of Quality Outcomes, including steps taken to ensure an appropriate resolution.

5. If the complaint was unable to be resolved, a meeting will be held between the complainant, Division Director and ultimately the President and Chief Executive Officer.

6. Every attempt will be made to resolve the grievance within a two-week period. When the complaint is resolved the "response" section of the Grievance Form will be completed by the Director of Quality Outcomes after he/she is notified of the resolution by the program director/coordinator and/or Division Director. A copy will be given to the client as well as placed in the client's permanent file.

7. The CQI committee will review grievances on a quarterly basis and the governing body will review resolution of client grievances annually. (Identifying information will be alerted to protect client confidentiality).

SaintA assumes responsibility in providing the resources necessary (e.g., interpretive services, TDD phone line, etc.) in order to effectively and appropriately communicate this process.

In the event that the grievance has not been resolved to the client’s satisfaction, the Director of Clinical Services will refer the issues to the appropriate party (Director of Quality Outcomes, SaintA Chief Clinical Officer, etc.) for resolution.

SaintA
Client Rights and Grievance Policy

Grievance Procedure:

SaintA shall, as part of the intake process, share information with clients concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance. At any time a complaint occurs, the client or other complainant shall be provided with a copy of the agency's Client Grievance and Requests for Administrative Review Policies and Procedures. Program staff shall be familiar with client rights and with these agency procedures. The program staff and their supervisor will forward the complaint to the local Clients Rights Specialist.

No sanctions will be threatened or imposed against any client who files a grievance, or any person including an employee of the agency, the department, or a county department or a service provider, who assists a client in filling a grievance of participates in or testifies in a grievance procedure or in any action for any remedy authorized by law.

If you have a concern about the services you are receiving, you are encouraged to discuss it with your therapist. If this does not resolve the issue, you may present a written complaint to the Program Supervisor or Clinic Administrator. If you are still not satisfied, please request a written copy of the Grievance Procedure.

Client Access to Records:

Under Wisconsin law, you have a right to review your treatment records. Ask your therapist for the procedures used in sharing your file with you. If you feel that it contains incorrect information, ask your therapist for the procedure used to request a change in record information.

Fee Policy:

A fee is charged for professional services provided by the therapists at SaintA (please refer to the Fee Policy & Fee Agreement). If you have private insurance or medical assistance, we will bill for services at the established rate. If you do not have insurance, or if our insurance does not pay in full, you will be responsible for paying the rate established on your Fee agreement. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used.

If you are receiving services under managed care, health insurance, medical assistance, or an EAP, the agency will need to obtain information about covered services, co-payments and deductibles, etc. The agency will either obtain the specific information required or ask you to obtain the information. Your signature on this form authorizes SaintA to release any information necessary to process insurance claims

Your Client Rights Specialist is:

Director of Quality Improvement
SaintA, Inc.
8901 W. Capitol Drive
Milwaukee, WI 53222
414-463-1880

SaintA
Client Rights and Grievance Policy

PARENTAL RIGHTS

As parents who have a child in one of SaintA's treatment programs, you and your child have a right to:

- be treated with respect and dignity at all times
- participate in the treatment decision-making process
- expect a safe, clean environment
- speak and visit with your child as frequently as permitted by the treatment plan
- to meet with the treatment team or contact individual members of the Team to discuss goals, interventions and progress
- be informed of any injury, illness, runaway or other significant occurrences within a reasonable period of time

Parents/guardians are informed of and receive a copy of these rights upon enrollment into a program. If there is a need to address any special communication or language barriers, SaintA, assumes responsibility in providing the resources necessary (e.g., interpretive services, TDD phone line, etc.) in order to effectively and appropriately communicate these rights.

STATEMENT OF CHILDREN'S RIGHTS

As an organization we believe every child, no matter the level of program involvement, is entitled to the following:

1. The right to enjoy freedom of thought, conscience, and religion.
2. The right to reasonable enjoyment of privacy.
3. The right to receive non-coercive service that protects the person's right to self-determination.
4. The right to have his/her parents or guardians, family members, and his/her opinions heard and to be included, to the greatest extent possible, when any treatment decisions are being made affecting his or her life.
5. The right to receive appropriate and reasonable adult guidance, support and supervision.
6. The right to be free from physical abuse and inhumane treatment. Every child has the right to be protected from all forms of sexual exploitation.
7. The right to receive adequate and appropriate medical care.
8. The right to receive adequate and appropriate food, clothing and housing.
9. The right to live in clean, safe surroundings.
10. The right to receive an educational program, which will maximize his/her potential.
11. The right to communicate with “significant others”. “Significant others” include family members and close friends whom the family has approved.

Clients are informed of and receive a copy of these rights upon enrollment into a program. If there is a need to address any special communication or language barriers, SaintA assumes responsibility in providing the resources necessary (e.g., interpretive services, TDD phone line, etc.) in order to effectively and appropriately communicate these rights.

SaintA
Client Rights and Grievance Policy

Attached is information regarding Client Rights and Grievance procedures for Community Based Services.

The caregiver and child should keep the attached three-page document.

The Client Rights and Grievance procedure has been explained to me. I understand the procedure and I have clarified any questions prior to signing this form.

_____ Date: _____
Client Signature (adult or minor age 12 or older)

_____ Date: _____
Signature of Guardian if signer is under the age of 18

_____ Date: _____
Signature of Clinician

The Clinic at SaintA

8901 W. Capitol Drive ● Milwaukee, WI 53222 ● 414-463-1880 ● Fax: 414-463-2770

CONFIDENTIALITY POLICY

It is the policy of SaintA that the information discussed with all parties during the course of treatment will be kept private. This means clinic staff may not discuss with anyone outside of SaintA the names of clients and family members they are working with.

However, there are instances when confidentiality cannot be maintained, such as:

1. A child or an adult reports a child has been abused or neglected (including sexual abuse or sexual activity between minors that is illegal), or clinic staff suspects abuse or neglect. In such instances, clinic staff are mandated by law to report the instance to Child Protective Services. Clinic staff must also report the incident to the case manager. It is not the responsibility of clinic staff to determine what constitutes “abuse” or “neglect”. It is the responsibility and legal obligation of clinic staff to make a report.
2. A Child or an adult harms, or threatens to harm another person. When threats are made, clinic staff are mandated by law to warn the person of the threat. Clinic staff must also report the incident to the care coordinator/case manager. A report to the authorities may also be made to ensure everyone’s safety. A report to the authorities is made if a child or an adult harms another person.
3. A child or an adult threaten to harm herself/himself. Clinic staff are mandated to contact the authorities, must contact the case manager, and anyone else to ensure the person’s safety.
4. Questionable physical punishment. It is not the responsibility of the Clinic staff to determine what constitutes appropriate and inappropriate punishment. It is the responsibility and legal obligation of Clinic staff to make a report to Child Protective Services. The case manager is also informed of the incident.
5. The legal guardian of a child or client, if an adult, signs a release of information form. Clinic staff is allowed to discuss the information discussed in sessions with certain individuals if given written permission.

Any questions regarding this policy may be directed to the Chief Program Officer of Community Services, SaintA at (414)463-1880.

I have received a copy of the Confidentiality Policy which has been explained to me. I understand the contents of each policy and have asked any questions I may have prior to signing this form.

Client Signature	**Date**
Parent/Guardian Signature	**Date**
Witness	**Date**

SaintA - INFORMATION FOR CLIENTS

The mission of SaintA is to provide innovative family-centered care and educational services that embrace diversity and empower children, families and adults to improve the quality of their lives. SaintA is a dynamic provider advancing foster care, education and mental health services. SaintA is a nonprofit organization providing counseling and psychotherapy for families. This sheet contains important information about our policies and procedures. Please read it carefully. Ask your therapist to answer any questions you may have.

Eligibility: Eligibility for SaintA mental health programs is based on the existence of a presenting problem. You may be referred to another community resource if you (1) do not meet the eligibility criteria; (2) there is not enough staff time available to help you; or (3) there is a more appropriate service provider elsewhere in the community or your insurance company has another counseling resource for you.

After you begin working with SaintA, services may continue; (1) so long as there are identified treatment goals which have not yet been met; and (2) there is evidence that you are interested in pursuing these goals.

The agency may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern of regularly missing appointments; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

Appointments: Appointments are scheduled with individual therapists. A therapy hour consists of a one 45-60 minute meeting with your therapist. If you need to cancel an appointment, please do so at least 24 hours in advance. You, not your insurance, will be billed for missed appointments.

Hours: The agency is open Monday through Friday 8:00 a.m. to 7:00 p.m. Evening hours are available by appointment.

Consultants: Your therapist collaborates with other licensed therapist in his/her clinical work. Your therapist also has a supervisor who may be contacted if you have questions or concerns. The supervisor will meet with you when necessary or at your request.

Confidentiality: All contacts between staff and clients are strictly confidential and will not be revealed to any person or agency outside of SaintA, without your written consent. The primary exception to this rule is those situations in which reporting is mandatory under Wisconsin law (e.g. child abuse, child neglect, sexual abuse, etc.). In addition, please note that your signature on the fee agreement give the agency permission to release information necessary for the processing of claims for payment.

Emergencies: In an emergency, you may call the office 24 hours, 7 days a week at 414-463-1880 to speak to your/a therapist. During non-working hours our answering system instructs you on how to contact a therapist and other emergency services. Following are a list of additional numbers to call in the event of an emergency:

SaintA Clinic On-Call
414-531-1407

Milwaukee County
Crisis Line
414-257-7222

Cope Services
262-377-2673

Grievance Procedure: SaintA shall, as part of the intake process, share information with clients concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance. At any time a complaint occurs, the client or other complainant shall be provided with a copy of the agency's Client Grievance and Requests for Administrative Review Policies and Procedures. Program staff shall be familiar with client rights and with these agency procedures. The program staff and their supervisor will forward the complaint to the local Client Rights Specialist.

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My signature below indicates that I have been given a copy of this information sheet, the "Client Rights and the Grievance Procedure for Community Services" brochure and the "SaintA Joint Notice of Privacy Practices". For clients age 12 – 17, I have been given a copy of the "Rights of Children and Adolescents in Outpatient Mental Health Treatment".

Signature (adult or minor age 12 or older)	Date:
Signature of Guardian if signer is under the age of 18:	Date:
Therapist Signature	Date:

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Signature (adult or minor age 12 or older)	Date:
Signature of Guardian if signer is under the age of 18:	Date:
Therapist Signature	Date:

SaintA

Consent for Admission for Mental Health/Substance Abuse Evaluation and/or Treatment

Name:
Date of Birth:
MRN:

1. **Consent to Evaluate/Treat:** I voluntarily consent that (please check one box) ☐ **I or** ☐**my child** will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from SaintA. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me or my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation or my child's evaluation and/or treatment is contained in a confidential record at SaintA, and I consent to disclosure for use by SaintA staff for the purpose of continuity of my child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if ☐ **I am or** ☐**my child** is deemed to present a danger to myself or himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Discharge Policy:** Most clients are discharged because they have successfully met the goals of their treatment plan and are no longer in need of services. If at any time, an assessment indicates that other services would be more beneficial to you, a referral to another provider will be provided. There are circumstances under which my child may be involuntarily discharged. If I or my child are noncompliant with treatment or pose a threat to the staff or other patients, my child may also be discharged.

6. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

7. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____
Signature of client (18 years or older) or legal representative **Date**

_____ _____
Signature of minor age 14 years or older (if applicable) **Date**

_____ _____
Signature of witness **Date**