



SALESMANSHIP CLUB
YOUTH AND FAMILY CENTERS

NOTICE OF OUR PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
 - Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or other practitioner.
 - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within Salesmanship Club Youth and Family Centers, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of Salesmanship Club Youth and Family Centers, such as releasing, transferring, or providing access to information about you to other parties.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission that is above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Texas Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners, the board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

PATIENT RIGHTS

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described previously). On your request, we will discuss with you the details of the accounting process.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy policy or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may complain to us using the contact information listed at the end of this Notice. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Jim Jackson
Contact Officer
Telephone: 214-915-4751
Email: jjackson@salesmanshipclub.org
Address: 106 E. Tenth St., Dallas, TX, 75203



SALESMANSHIP CLUB
YOUTH AND FAMILY CENTERS

106 EAST TENTH ST. • DALLAS, TEXAS 75203
Phone 214-915-4700 • Fax 214-915-4748

WWW.SALESMANSHIPCLUB.ORG

9705 Harry Hines Blvd. • Dallas, Texas 75220
Phone 214-916-4000 • Fax 214-916-4001

**THERAPEUTIC SERVICES
INFORMED CONSENT**

Welcome to Salesmanship Club Youth and Family Centers. It is important to us that you know what to expect from the services you receive at our offices. For this reason, we ask that you read and understand the information provided here, as it explains several aspects of how we work. Please ask us if there is anything unclear to you. We will be glad to explain it in more detail.

Salesmanship Club Youth and Family Centers, Inc., is a private, nonprofit agency committed to providing excellent services to all families. Licensed mental health professionals, educational specialists, parent educators, trainees, and other staff provide therapy, groups, assessment, and parenting education.

RISKS AND BENEFITS OF THERAPEUTIC SERVICES. Participating in our programs can have both benefits and risks. It may not by itself resolve your problem or concern. There may be discomfort associated with the discussion of difficult issues and with change. On the other hand, these services have been shown to have many benefits. They often lead to a better understanding of problems and to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Of course, there are no guarantees as to what your experience will be. During the first few visits, our staff will be working toward developing an understanding of your needs and offering you some information regarding what your work together will include. Since our programs involve a commitment of your time and energy, you should evaluate the information our staff shares, along with your own opinions, to be sure you are comfortable working with us. If our staff or you find that we are unable to assist you, we will provide you with a referral to another therapist or agency if you so desire.

Please keep in mind that our services are not like a medical doctor visit. Instead, they call for a very active effort on your part. For your experience to be most successful we ask that you be engaged in the process both during your time at our offices and at home. At any time, you may ask our staff why we are gathering information or using a particular approach. We will be happy to explain the thinking behind our actions and approaches.

Your relationship with Salesmanship Club Youth and Family Centers staff is a professional relationship. In order to preserve this relationship, staff cannot have other types of business or personal relationships with you. We will do all we can to treat you professionally with dignity and respect and if at any time we miss the mark we welcome your feedback.

CONFIDENTIALITY. The law protects the privacy of communications between you and our staff. In most cases, our staff can only release information about your treatment to others when you sign an *Authorization for Use and Disclosure of Protected Health Information*. There are other situations that don't require your written, advance consent. These activities are defined as *treatment, payment and health care operations*, and are explained in more detail in the attached *Notice of Privacy Practices*. By signing the *Therapeutic Services Informed Consent*, you are providing consent for these activities.

If you participate in marital or joint therapy sessions, you consent for Salesmanship Club Youth and Family Centers to maintain a single case file for all joint sessions and to release all information contained in the file for joint sessions to any adult participant in the joint session upon request by a participant.

We believe that consultation and supervision among our clinical staff translates into better services for you. By signing you consent to allow our clinical staff to discuss details of your situation with each other in a respectful, careful and private manner for the purpose of supervision and consultation only.

There are a limited number of situations when your rights to confidentiality do not apply, including but not limited to the following: a) child abuse; b) elder abuse; c) sexual exploitation; d) situations where we have a duty to disclose, or where, in our judgment, it is necessary to warn, notify, or disclose. These situations are also outlined in the attached *Notice of Privacy Practices*. We urge you to carefully read the *Notice* and share with us any concerns you might have regarding the confidentiality of your information.

CUSTODY DISPUTES. Our therapeutic team supports a cooperative parenting approach in working with divorcing, divorced or conflicted parents. Therefore we will not do evaluations to determine fitness for parental custody nor will we take a position about who should be awarded custody. By signing the *Therapeutic Services Informed Consent*, you are agreeing not to call any of our staff to court in a custody dispute.

APPOINTMENTS. We ask that you do your very best to honor your commitment to us by arriving on time for appointments. If you will not be able to keep your appointment, please notify us at least 24 hours in advance.

TERMINATION OF SERVICES. You may choose to leave our services at any time, but this is best accomplished in consultation with our staff. If you are dissatisfied with the course of services, we encourage you to talk with your therapist, group leader, or her/his supervisor. Your services here may be terminated by us either verbally or in writing for any of the following reasons: (a) Missing two consecutive appointments without prior notification; (b) threatening or abusive remarks/behavior to any of our staff members; or (c) failure to follow important recommendations (i.e., medical referrals, suicide interventions, safety contracts).

OBSERVATION, SUPERVISION AND VIDEOTAPING. Observation, supervision, and videotaping can be useful in your treatment and allow for instruction and input that ensure the highest quality service possible. These practices will be used during assessments and may be used by your therapist or group leader to clarify her/his understanding and to help formulate new ideas to address your concerns. **At no time will these practices be used without your full knowledge.** Your therapist or group leader will explain these practices further and address any concerns you might have should she/he decide they would be helpful in her/his work with you.

PHONE CALLS AND EMERGENCIES. Due to appointment schedules, it may be several hours before your therapist or group leader can return your call. Calls received late in the day may not be returned until the following day. Weekend calls are generally not returned until the following Monday. In an emergency, please call 911 or CONTACT at (972) 233-2233. You may also go to the nearest hospital or emergency room.

FEES. Since Salesmanship Club Youth and Family Centers is a nonprofit agency committed to serving children and families, we are able to provide quality services at affordable rates. The fees for each program vary and will be discussed with you at the time of service. For families in need of assistance, we provide grants to help cover the cost of service. On the *Financial Arrangements* page of this packet, a fee will be assessed based on your ability to pay.

Thank you for taking the time to read over this important information. It matters a great deal to us that you feel respected and informed in this process. With your signature on the attached *Therapeutic Services Informed Consent*, you are stating that you understand all policies and agree to abide by all conditions stated in this form.

We appreciate the opportunity to work together and hope that you will always feel free to discuss with us any concerns you have about our practices.

Office Use
Client Code:

**Salesmanship Club Youth and Family Centers
Therapeutic Services
Informed Consent**

I have received a copy of the Salesmanship Club Youth and Family Centers (SCYFC) Therapeutic Services Informed Consent document and have read and understand the statements. I have also received a copy of SCYFC's Privacy Practices. I consent for SCYFC staff to work with me and I understand that I may discuss any questions I may have regarding this information with staff. My signature below indicates that I give my full and informed consent to receive services, including supervision and consultation as well as, with advance notice, observation or videotaping.

Adult Signature

Adult Signature

Print Name

Print Name

Date

Date

Consent for the Assessment and/or Treatment of Minors

I am the legal guardian of the minor children listed on the attached application and I give permission for staff of Salesmanship Club Youth and Family Centers to provide treatment and other services to my aforementioned minor children. *(If you are not the legal guardian of the children, please discuss this issue with a staff member prior to the session).*

Signature of Legal Guardian

Printed Name

Date

**CONSENT FOR PARTICIPATION IN RESEARCH, TRAINING PROGRAMS and
VOLUNTEER PROGRAMS**

Our services are offered on a sliding fee scale basis, making them affordable to all members of the community. In return, we ask every client to participate in our research program.

SCYFC is an active research and learning community. Our staff is committed to identifying those strategies that children and families find *most helpful* in reducing the severity of their problems. Lessons learned are shared with other agencies throughout the United States, and the confidentiality of all clients is respected at all times.

At different points throughout your participation in SCYFC programs, including follow-ups after you complete services with us, you will be given questionnaires that ask you for honest feedback about what was helpful, what was not helpful and what could be improved in our services. Your responses will be collected by the members of our research team, so that they can evaluate the overall effectiveness of our therapeutic programs. Please take the time to fill out these questionnaires when you receive them. It will help us improve our work, which in turn will benefit other children and families.

In addition, we have professional training programs for graduate students and other professionals who are working toward licensure. SCYFC programs provide a direct learning experience for these individuals. As stated in the *Informed Consent*, all participants in the training programs are under direct supervision of a licensed mental health professional and will be identified as persons in training who receive supervision.

Finally, we are able to offer our services for a fee affordable to every family because of the generous support of the Salesmanship Club of Dallas, the United Way of Metropolitan Dallas, and sponsors of our largest fundraiser, the HP Byron Nelson Championship. In order to help our patrons and sponsors fully understand and appreciate the important services we offer, we occasionally invite them or other volunteers to participate in services. This may include tours of the facilities, presentation of de-identified cases, observation of groups, or even participation in some select activities. By signing this consent you give permission for your child and yourself to be in contact with volunteers in a non-therapeutic setting and understand that while SCYFC staff will keep personal information confidential, it is possible that incidental disclosures of information could occur through informal conversation with other program participants.

In signing below, I confirm that I agree to participate in the SCYFC research and with personnel involved in training and volunteer programs

Signature

Date

We want to reach more families in the Dallas area who may need services. Please help by sharing how you heard about us. (Check all that apply and please be as detailed as possible.)

- Staff member at another Salesmanship program Name: _____
- Courts (Juvenile Dept., Lawyer, CPS, Probation Officer) Name: _____
- Community agency Name: _____
- Friend or family member Name: _____
- Newspaper/Magazine article Publication: _____
- SCYFC brochure, newsletter, or annual report
- Hospital or doctor Name: _____
- School counselor or teacher Name of school: _____ Name of Person: _____
- Internet Site: _____
- Yellow Pages
- Insurance company or Medicaid
- Therapist or counselor Name: _____
- TV or radio
- Other Name: _____

How do you think we should get the word out about our services? _____



Office Use
Location: OC FW
Prog: FT EC TASP
Clinician:
IP Client Code:

Date: _____

THERAPEUTIC SERVICES APPLICATION

Welcome to our office! We look forward to working with you.

PLEASE CIRCLE ANY INFORMATION YOU PROVIDE BELOW THAT YOU PREFER WE NOT USE TO CONTACT YOU.

Your Name: _____ Date of Birth: ___/___/___
Month Day Year

Address: _____ City: _____ Zip: _____ County: _____

[Empty box for marking preferred information]

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Email: _____

Race: []Asian []African American/Black []Caucasian []Hispanic/Latino []Native American []Other _____

Spouse/Partner's Name: _____ Date of Birth: ___/___/___
Month Day Year

Address: _____ City: _____ Zip: _____ County: _____

[Empty box for marking preferred information]

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Email: _____

Race: []Asian []African American/Black []Caucasian []Hispanic/Latino []Native American []Other _____

Which language do you prefer? English Spanish

CHILD FOR WHOM YOU ARE SEEKING SERVICES:

Name: _____ Sex: Female__ Male__ Date of Birth: ___/___/___ Age: ___
Month Day Year

[Empty box for marking preferred information]

Race: []Asian []African American/Black []Caucasian []Hispanic/Latino []Native American []Other _____

Who has legal custody of this child? _____ How are you related to this child? _____

This child's parents are (please circle): Married Separated Divorced Widowed Never Married to One Another

Is there a parent/guardian not living in the home? _____

Name and contact information of other parent/guardian: _____

OTHER CHILDREN IN THE HOME:

Name: _____ Sex: Female__ Male__ Date of Birth: ____/____/____ Age: ____
Month Day Year

Race: Asian African American/Black Caucasian Hispanic/Latino Native American Other _____

Who has legal custody of this child? _____ How are you related to this child? _____

This child's parents are (please circle): Married Separated Divorced Widowed Never Married to One Another

Is there a parent/guardian not living in the home? _____

Name and Contact information of other parent/guardian: _____

Name: _____ Sex: Female__ Male__ Date of Birth: ____/____/____ Age: ____
Month Day Year

Race: Asian African American/Black Caucasian Hispanic/Latino Native American Other _____

Who has legal custody of this child? _____ How are you related to this child? _____

This child's parents are (please circle): Married Separated Divorced Widowed Never Married to One Another

Is there a parent/guardian not living in the home? _____

Name and Contact information of other parent/guardian: _____

Name: _____ Sex: Female__ Male__ Date of Birth: ____/____/____ Age: ____
Month Day Year

Race: Asian African American/Black Caucasian Hispanic/Latino Native American Other _____

Who has legal custody of this child? _____ How are you related to this child? _____

This child's parents are (please circle): Married Separated Divorced Widowed Never Married to One Another

Is there a parent/guardian not living in the home? _____

Name and Contact information of other parent/guardian: _____

Name: _____ Sex: Female__ Male__ Date of Birth: ____/____/____ Age: ____
Month Day Year

Race: Asian African American/Black Caucasian Hispanic/Latino Native American Other _____

Who has legal custody of this child? _____ How are you related to this child? _____

This child's parents are (please circle): Married Separated Divorced Widowed Never Married to One Another

Is there a parent/guardian not living in the home? _____

Name and contact information of other parent/guardian: _____

OTHER ADULTS IN THE HOME ___ None

Name: _____ Date of Birth: ___/___/___ Relation to family: _____

Name: _____ Date of Birth: ___/___/___ Relation to family: _____

Name: _____ Date of Birth: ___/___/___ Relation to family: _____

Do you have children who do not live in your home? ___ If yes, provide the information requested below:

Name: _____ Date of Birth: ___/___/___ Lives with: _____

Name: _____ Date of Birth: ___/___/___ Lives with: _____

Emergency contact (not living in your home): _____ **Relationship to you:** _____

Address: _____ **Phone:** _____

PLEASE LIST THE NAMES OF INDIVIDUALS AND NAMES OF AGENCIES OF OTHER MENTAL HEALTH PROVIDERS FROM WHOM YOU'VE RECEIVED SERVICES:

Name: _____ **Agency:** _____

Name: _____ **Agency:** _____

Name: _____ **Agency:** _____

Name: _____ **Agency:** _____

Thank you for taking the time to share this information with us.

For research purposes, please answer the following:

HAVE YOU OR OTHER FAMILY MEMBERS:	
1. been in counseling before?	YES NO
2...been placed in a hospital or residential program for emotional or behavioral problems?	YES NO
3... ever completed psychological testing?	YES NO
4... ever repeated a grade in school?	YES NO
5... had behavior or discipline problems in school?	YES NO
6... had academic/learning problems at school?	YES NO
7... ever had educational testing for learning or behavior issues at school?	YES NO
8... ever been involved with the legal system (criminal, divorce, custody, civil, etc.)?	YES NO
9. Are you or other family members currently involved with the legal system?	YES NO
10. Do you or other family members currently take medication for emotional/behavioral problems?	YES NO
11. Is there a family history of mental or emotional illness in your family?	YES NO
HAVE YOU OR OTHER FAMILY MEMBERS EXPERIENCED ANY OF THE FOLLOWING PROBLEMS?	
1. Mental Illness	YES NO
2. Depression	YES NO
3. Neglect	YES NO
4. Sexual Offense	YES NO
5. Financial Difficulty	YES NO
6. Emotional Abuse	YES NO
7. Physical Abuse	YES NO
8. Sexual Abuse	YES NO
9. Alcohol Abuse	YES NO
10. Drug Abuse	YES NO

For research purposes, please indicate your income bracket below:

ANNUAL INCOME	√	ANNUAL INCOME	√
Under 10,000		45,001-55,000	
10,000-25,000		55,001-70,000	
25,001-35,000		70,001-80,000	
35,001-45,000		80,000 +	