



Notice of Privacy Practices Acknowledgement of Receipt

The Notice of Privacy Practices tells you how RMYA may use or disclose information about you. Not all situations will be described. RMYA is required to give you a notice of our privacy practices for the information we collect and keep about you.

I, _____ (client's name, or if in a case of a minor, the legal representative), have been given a copy of RMYA'S Notice of Privacy Practices.

Client's Name

Date

Legal Representative Signature

Date

Effective Date: April 14, 2003



Parenting Class Client Information

Client Name: _____

Registration Date: _____

Sex: Male Female SSN: _____ - _____ - _____ DOB: _____ Marital Status: _____

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Other Phone (____) _____ - _____

Employer: _____ Phone: (____) _____ - _____

Address: _____
(Street) (City) (State) (Zip Code)

Number of People in Household: _____

Ethnic Origin: Asian American Indian/Alaskan Native African American Caucasian Hispanic
Other: _____

Religious Affiliation: Atheist Baptist Catholic Christian (Non-Denominational) Jewish Muslim
 No Preference Other: _____

Family Annual Income: under \$10,000 \$10,000-14,999 \$15,000-29,999 \$30,000-49,999
 \$50,000+

In Case of Emergency Notify: _____ Relationship to client: _____
Phone Number: (____) _____ - _____

Who referred you to parenting classes: Self Court DFPS (CPS) BCJP Adult Probation
 Other: _____

Reason for referral:

Is Child Protective Services, Bexar County Juvenile Probation Department, or Bexar County Adult Probation currently involved with your family?

No

Yes -What is the charge/offense cited (if probation): _____

Name of the referring agency: _____

Agency Representative: _____

Address & Phone Number:

() -

Would you like RMYA, Inc. to have permission to disclose and receive only the information identified on the Authorization of Release of Information Form?

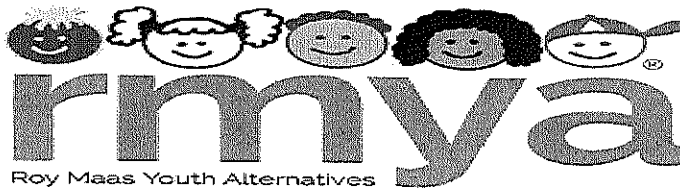
Yes -Please fill out the Authorization of Release of Information Form at the end of this packet.

No

Please indicate if you are interested in seeking family counseling services: Yes No

Please provide names of your children you reside with:

Name	DOB	Age	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



Consent for Services

I, _____, request that Roy Maas' Youth Alternatives Counseling Center provide the "Becoming a Parent with Love and Logic Program" classes to me in order to address the issues and achieve the goals we set with your counselor.

Informed Consent

I understand each program is just seven weeks. Plus, each class will be an hour in length. I understand degreed professionals and clinical interns will provide the classes, which may be reviewed in supervision with other degreed professionals. Should I miss a class, I will not receive credit for completion of the program. I understand that I must make up any missed classes in the next term or I may make up the class in a private session. The fee for private sessions will exceed the class fee and will be based on the client's income. I understand I may not be late to class according to the RMYA clock, no exceptions. This means that you must be signed in to be in compliance with this rule.

Financial Agreement

"Becoming a Parent with Love and Logic Program" classes are offered to parents free of charge; however there is a materials fee of \$7 per class. A discount will be provided to class participants that pay for the course on/prior to their first class for a fee of \$35. If a participant wishes to make up a class, it will be considered a private therapy session and the fee will be based on the client's income.

Limits of Confidentiality

I understand the contents of counseling sessions are protected by confidentiality. I understand that the Limits of Confidentiality are, but not limited to, the following: 1) records may be subpoenaed by the courts; 2) allegations of physical abuse, sexual abuse, and or neglect are reportable to Child Protective Services; 3) assessments by the therapist that the youth/adult is a danger to his/her self or others; 4) information about breaking the law, and 5) at-risk behaviors such, such as issues relating to the youth's/adult's safety or health. I further understand that keeping confidentiality cannot be guaranteed by all class/group attendees. I agree to respect the confidentiality cannot be guaranteed by all class/group attendees. I agree to respect the confidentiality and privacy of all class/group members.

RMYAS Notice of Privacy Practice

Please refer to RMYA's Notice of Privacy Practices to find out how protected information about you may be used, disclosed, and how you can access information.

Future Follow Up Contact

I understand that RMYA will contact me after services have ended. The contact will be by phone or by mail. The reason for following up will be to assess the home situation and changes since receiving counseling services. Attempts will be made 30 days after services end.

Counseling Services

I understand that RMYA Counseling Center offers counseling services with youth ages 0-17 years old. I am welcomed to attend these sessions and will notify the office if my family is interested. My family can receive counseling services while I am attending the parenting classes or may return at a later date.

Client Files

Client files are property of Roy Maas' Youth Alternatives.

Referred By Agency

Before RMYA can verify your attendance with a referring agency (examples: Child Protective Services, Bexar County Juvenile Probation, or Bexar County Adult Probation) at our counseling program, a release of information must be filled out.

Suggestions/Compliments/Complaints

RMYA welcomes suggestions from our clients on ways to improve services. Clients may call the office (210-340-7971) and speak to the Director of the Counseling Center or submit their comments in writing.

I verify that I have read the Request for Professional Services

Client Signature: _____

Date: _____

Therapist Signature: _____

Date: _____



Authorization of Release of Information

I _____ (Client or Legal Guardian in the case of Minors) give Roy Maas' Youth Alternatives Inc. permission to disclose and receive only the information I have identified on this authorization form to the person(s) or entity I have named only for the purpose I have identified. I understand that this will include information relating to: (check, if applicable) AIDS and/or HIV Behavioral health services/psychiatric care Treatment for alcohol and/or drug abuse

Client Information:

Client Name: _____ D.O.B: _____

Address: _____

The Information shall be disclosed to the following person(s) or entity:

Person/ Agency Name: _____

Address: _____

Type of Information to be disclosed:

- Treatment Plan Dates of service Educational Information Medical Information
 Testing/Assessments Summary of Participation in the Program Psychological Assessments
 Other (please specify): _____

The Information disclosed shall cover health care for the following periods of time:

From: (month/date/year) _____ To: (month/date/year) _____

Conditions of this Release of Information: This authorization is valid for one year from the date I sign unless revoked prior to that date I may revoke this authorization in writing at any time. This authorization cannot be revoked to the extent that RMYA has taken action in reliance on the authorization. This information may be re-disclosed by the person(s) or entity receiving the information.

Client/Legal Guardian Signature

Date