LifePointe
Counseling, LLC

Healing Hearts ✧ Restoring Hope

NEW CLIENT PACKET FOR MINORS

Welcome to LifePointe Counseling, LLC and thank you for choosing us for your counseling needs! We are committed to giving you the best possible care and service. To acquaint you further with our policies and procedures we are providing you with the following information. Please carefully read this information before signing at the bottom of each page, then complete all the registration information (pages three and four). If we are billing insurance on your behalf, please be sure to fill out your insurance company name, subscriber name and date of birth, etc. Please ask the front office staff or your counselor if you have any questions.

LifePointe Counseling, LLC is a group of independent medical health professionals, under the name of LifePointe Counseling, LLC. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While the members share a name and office space, we want you to know that the clinician(s) you are seeing here are fully responsible for those services. Their professional records are the property of LifePointe Counseling, LLC; however, no other member of the group can have access to them without your specific written permission. In addition, your provider(s) are solely responsible for matters concerning your clinical care and all questions about that care should be addressed to them.

Appointments: Your time is valuable – and so is your counselor's. If you need to cancel an appointment, we require a minimum of 24 hours notice so that we can offer your time slot to another waiting client. If you are not able to call and cancel during normal business hours, we do have an automated voice mail system that will record your cancellation message. Simply call us at 314-849-2120 and leave a message on the voice mail system; otherwise, you will be charged a **late cancellation/no show fee of at least $50 per missed session.** Please note that LifePointe Counseling, LLC does reserve the right to terminate services or deny assistance to any patient who communicates with any staff member in an abusive, profane, threatening or unprofessional manner.

Emergencies: In case of an after-hours emergency, please keep yourself safe and go the nearest emergency room or dial '911' for help. LifePointe Counseling, LLC does not provide emergency services. We do not have 24-hour staff and we are not affiliated with a hospital. Arrangements for after hours or nontraditional services must be discussed and established in writing with your provider. If you need emergency mental health care, please call the Behavioral Response Hotline at 1-800-811-4760.

Financial Responsibility: You are fully responsible for payment of all services provided to you. Full payment is expected at the time of service unless prior arrangements have been made. **Insurance co-pays and co-insurance payments must be paid at the time of service in order to schedule a follow-up appointment.** If your insurance provider changes during the course of your treatment, please contact our medical biller at 314-266-1425 and make sure that your new benefits will help cover our services. Otherwise, significant out-of-pocket expenses may occur.

Please make all checks payable to "LifePointe" or "LifePointe Counseling, LLC". We also offer payment via credit and debit cards for the majority of our providers (please note an additional 3% is charged with all credit and/or debit payments). Payments made by cash must be made in **exact change**, as no cash money is kept on site. Please note that effective August 1, 2018, any accounts that are sixty (60) days or more past due will be subject to a delinquent fee surcharge as allowed under Missouri law. Past due accounts are subject to 5% interest on the balance after sixty (60) days. Should your account become delinquent beyond 60 days, you will no longer be able to schedule an appointment or receive prescription refills. For details on our financial policies, please see the front staff or visit our website at www.lifepointecounseling.com and click on the "FORMS" tab, which will direct you to a webpage where you can download our document entitled "Financial Policies".

I have read and understand all the above information, agree to the terms/conditions set herein, and consent to receive treatment LifePointe Counseling, LLC.

______________________________________ ____________________

Client/Guardian Signature **Date**

If any payments are made by check and returned as "non-sufficient" your account will be billed a $40 charge for banking fees and re-processing of your claim. At any time, if you have questions about your billing, please call our medical biller at 314-266-1425. We are only able to discuss your account with you, your guarantor, or your insurance company due to medical privacy laws. **Should any of your accounts at LifePointe Counseling, LLC become delinquent beyond 60 days, you will no longer be able to schedule an appointment or receive prescription refills.** If any of these financial procedures present a problem for you or your treatment, please discuss your concerns with your LifePointe Provider or Office Staff.

Insurance Billing: LifePointe submits insurance claims to in-network companies only. If you choose to see a provider that is not in your network, you are required to make full payment at the time of service. We can provide you with a copy of your paid bill for you to submit to your insurance for out-of-network reimbursement.

If you see a counselor or doctor here at LifePointe Counseling, LLC that is contracted with your insurance provider, we will be happy to bill your insurance on your behalf. You will still owe your co-pay at the time of service. **We also strongly recommend that you know and verify all your benefits; specifically, your co-pays/co-insurance, deductibles, authorization requirements, etc., prior to your first visit.** We cannot emphasize enough how important this can be in light of the ever-changing health care laws and insurance policy changes we all contend with today.

If your insurance coverage/plan changes, you must contact us with this information prior to your next scheduled visit so that we can both be sure your visit will be covered and what benefits/payments apply. You are responsible for the co-payment(s), deductible, and non-covered expenses as determined by your insurance plan. Please know that the insurance company(ies) quotation of benefits is not a guarantee of payment and you are responsible for any fees/services rejected by your insurance plan.

Confidentiality: Your patient records are the property of LifePointe Counseling, LLC and are treated as confidential. Your records will not be released without your executed written consent, unless special circumstances arise. We are obligated to release certain information to get claims processed by your insurance company. Please talk to our office manager if you have any further questions.

LifePointe Counseling, LLC providers do not have an encrypted email or intranet system. Text messages are managed and stored in remote servers for a time by most wireless service providers. Therefore, most communication via email, text, skype, etc. is NOT secure and therefore should not be used to transfer private or sensitive information. If you choose to communicate with your provider via electronic means, you do so with the understanding that your privacy may not be guaranteed electronically. Also, a copy of email or written communication sent to clinicians working with LifePointe Counseling, LLC will be maintained in the clinical record of the person served and may not be released to other providers. Please ask your provider for the secure fax number, voicemail number, and mailing address in order to send information remotely.

Contact Information: It is vital that you keep your contact information up-to-date with our office. If any of your information changes, please let us know so we can update your records. This would include any changes to your surname, address, home/cell/work phone numbers, marital status, employer/school, emergency contact information, primary care physician, and/or financial responsible party (Guarantor of your account balances). Without up-to-date information we may be unable to contact you to confirm, reschedule or cancel an appointment, file your insurance claims properly, and/or refill your prescriptions.

Services Rendered: I understand that seeing a provider for an Initial Diagnostic Evaluation is not a guarantee that future medication management and/or therapy services will be provided. I understand that the first few sessions with my Provider are a time for both the provider and patient to discuss and assess the issues that the patient wants to address. During this time both parties will also determine whether or not the therapeutic relationship is a good fit for both parties. Because there are many different types of providers who specialize in a variety of areas, I understand that I may be referred to another provider for more specialized care.

I have read and understand all the above information, agree to the terms/conditions set herein, and consent to receive treatment at LifePointe Counseling, LLC.

______________________________ ______________

Client/Guardian Signature **Date**

CLIENT REGISTRATION

~ Patient Information ~

1. Patient Name ____
(Last) (First) (Middle Initial) (Nickname)

2. Full Address (Street, City, Zip) ____

3. Primary Phone: ( ) ____________________ ☐ Cell ☐ Home ☐ Work 4. Secondary Phone: ( ) ___________________ ☐ Cell ☐ Home ☐ Work

5. Gender: ☐ M ☐ F ☐ Other ______________________ 6. Marital Status: S M D W 7. Birthdate ______________________ Age: ___________

8. Driver License No. ______________________________________ 9. Soc. Sec. # (Tricare Clients Only): ______________________________________

10. Employer: ____________________________ Occupation: ______________________ 11. Student/School: ____________________ ☐ Full-Time ☐ Part-Time

12. If dependent child, are custodial parents: ☐ Married ☐ Separated ☐ Divorced ☐ Other ______________________________________

13. Primary Care Physician: ____
(Name) (Phone)

14. IN CASE OF EMERGENCY NOTIFY: Name ______________________________________ Relationship ____________ Phone ( ) ____________________

Full Address ____

~ Financially Responsible Party (Guarantor) Information ~

If same as patient, please complete only question #1 in this section.

1. Guarantor Name ____
(Last) (First) (Middle Initial) (Nickname)

2. Guarantor Address (Full) ____

3. Guarantor Relationship to Patient (check one): ☐ Spouse ☐ Mother ☐ Father ☐ Sibling ☐ Friend ☐ Other ______________________________________

4. Primary Phone: ( ) ____________________ ☐ Cell ☐ Home ☐ Work 5. Secondary Phone: ( ) ___________________ ☐ Cell ☐ Home ☐ Work

6. Special Financial Arrangements: ____

~ Insurance Information ~

1. Do you have insurance? ☐ YES ☐ NO (If yes, please complete below) ** **Please note LifePointe does not do Out-Of-Network billing****

2. *Primary Insurance Co. Name: ______________________________________ Claims Phone #: ______________________________________

Insurance Claims Address: ____

3. Subscriber's Name: ______________________________________ 4. Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other __________

Employer: ______________________________________ Subscriber SSN: (Tricare clients only) ______________________________________

5. Member ID # ______________________________________ 6. Group ID # ___________________________ 7. Subscriber Birthdate: ____________________

8. *Secondary Insurance Co. Name: ______________________________________ Claims Phone #: ______________________________________

Insurance Claims Address: ____

9. Subscriber's Name: ______________________________________ 10. Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other __________

Employer: ______________________________________ Work Phone: ( ) ______________________________________

11. Member ID # ______________________________________ 12. Group ID # ____________________________ 13. Birthdate _______________

IF YOUR LIFEPOINTE COUNSELING, LLC PROVIDER IS CONTRACTED TO BILL YOUR INSURANCE PLAN, PLEASE SIGN THE FOLLOWING SECTION: ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to LifePointe Counseling, LLC the amount due for services rendered to me or my dependents. RELEASE OF INFORMATION: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to my dependent or me. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

SIGNED: ______________________________________ ______________________________________ DATE: ________________________
Insured Patient/Guardian

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by LifePointe Counseling, LLC. If the provider is contracted with the insurance company, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan:

Guarantor Signature (Patient signature, if patient is guarantor) ______________________________________ DATE: ______________________

WHO REFERRED YOU / HOW DID YOU HEAR ABOUT US?

☐ **Physician** ☐ **LifePointe Staff Member** ☐ **Friend** ☐ **Church:** ______________________

☐ **Facebook** ☐ **Psychology Today** ☐ **JoyFM/Radio** ☐ **Other:** ______________________

CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS

Please note that a copy of our Payment Policies, HIPAA Statement, Notice of Privacy Policies and Client Rights Statement, and other important documents are available on our website at www.lifepointecounseling.com. You may access these documents by going to our homepage, selecting "FORMS", then clicking on the corresponding document.

******Areas within (_________) are to be initialed by the client or authorized person.******

FINANCIAL POLICIES: I acknowledge having been offered LifePointe Counseling, LLC's Financial Policies document. (_______)

PRIVACY POLICY: I acknowledge having been offered LifePointe Counseling, LLC's Notice of Privacy Policies and Client Rights Statement. (________)

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by LifePointe Counseling, LLC and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. (____________)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of LifePointe Counseling, LLC. I authorize LifePointe Counseling, LLC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that LifePointe Counseling, LLC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (__________)

______________________________ ______________________ ______________________

Client or Authorized Person Signature Relationship Date

____ ______________________

Witness Signature Date

~ Child and Adolescent Consent for Treatment (If Applicable) ~

Patient Name (printed): ____________________________________ Birthdate: ______________

Last Name First Name Middle Initial

I certify that I am the (check one) ☐ father ☐ mother ☐ legal guardian of the above-named child/adolescent and that I do have legal custody of the above-named child/adolescent. I, hereby, give my authorization and consent for the above-named child/adolescent to receive outpatient assessment/therapy from (therapist name) ______________________.

Printed Name: ____

____ ______________________

Signature Date

~ Divorce/Legal Separation Collection Policy (If Applicable) ~

It is the policy of LifePointe Counseling, LLC that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for payment of the child's/adolescent's treatment regardless of any financial arrangement for payment of the child's/adolescent's medical care, either oral or written, with the child's/adolescent's other parent or responsible party. LifePointe Counseling, LLC. assumes no responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child's/adolescent's medical care. **I have read, understood and agree to the above policy:**

Printed Name: ____

____ ______________________

Signature Date

____ ______________________

Witness Date

ADDITIONAL INTAKE PAPERWORK FOR PARENTS/GUARDIANS OF MINORS BEING SEEN BY FIONA HILL, MTS, MA, LPC

(Page 1 of 2)

PRIOR TO THE FIRST APPOINTMENT:

- There is a short intake packet entitled "New Client Packet for Minors" that we ask each prospective client's legal guardian(s) to complete prior to being seen. You can access this form on our website at www.lifepointecounseling.com/minors to download, print, and complete this packet prior to your child's/teen's first appointment. If you are unable to complete the packet beforehand, please plan to arrive 20 minutes early so that this packet can be completed without interrupting session time. Blank packets will be printed on colored paper and located on clipboards in our office lobby.
- If custody is shared by separated and/or divorced parents, **BOTH** parents must sign the documents prior to the child being seen. If rights have been terminated, or a parent does not have any say in treatment, documentation of this is necessary in order to provide treatment.
- If the child is under a guardianship order, the legal guardian must be present when the child is seen.
- For minors in custody of the Missouri Division of Family Services, you must provide a copy of the placement letter from DFS on their letterhead indicating your (legal) ability to make healthcare decisions on the minor's behalf.
- If you have temporary custody or permanent guardianship over the minor, you are required to provide proof of guardianship paperwork at or before the first visit.
- It is important to bring any legal documents that have been drafted (custody agreements, adoption papers, orders of protection, guardianship documents, DFS documents, pertinent police reports filed, etc.) to this first appointment.

WHAT TO EXPECT AT YOUR FIRST SESSION:

- **Minors cannot be seen unless they are accompanied by parent or legal guardian.**
- The provider will give a brief introduction of how counseling will work, along with agency policies, to further ensure you understand what the process will look like each step along the way.
- While assessment is an ongoing process throughout treatment, the first session will be a time to gather information regarding presenting concerns, social history, medical treatment history and mental health treatment history.
- **IMPORTANT:** Therapy sessions are a very special time for you and your child/teen to connect with each other. Please do not bring other family members (e.g. siblings, cousins, etc.) or friends to the therapy session(s) so that this time can be the most productive for everyone.

____ ________________

Legal Guardian #1 Signature **Date**

____ ________________

Legal Guardian #2 Signature **Date**

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ADDITIONAL INTAKE PAPERWORK FOR PARENTS/GUARDIANS OF MINORS BEING SEEN BY FIONA HILL, MTS, MA, LPC

If you must bring other children under 12 years of age, please bring another trusted adult with you who can supervise them while they wait for you in the reception room. We respectfully request this so that (1) the session isn't interrupted by other children; (2) so that the therapist can meet with parent(s) individually in order to complete a thorough assessment, as there may be some information you do not want your child to hear; (3) client sessions taking place with other providers in the office will not be disturbed; and (4) the providers and office staff of LifePointe Counseling, LLC cannot be responsible for anyone left unattended and cannot guarantee a space where they are not left unattended.

Are there any contact restrictions? (circle one) **Yes** **No**

If yes, please explain (documentation required):

____

____

____

Is legal/physical custody shared? (circle one) **Yes** **No**

If yes, please explain (documentation required):

____

____

____

Parent Name: ______________________

_______ Mother _______ Father _______ Guardian

_______ Other: ______________________

Legal Guardian? *(circle one)* Yes No

Street Address: ______________________

City, State, Zip: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Work Phone: ______________________

Parent Name: ______________________

_______ Mother _______ Father _______ Guardian

_______ Other: ______________________

Legal Guardian? *(circle one)* Yes No

Street Address: ______________________

City, State, Zip: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Work Phone: ______________________

______________________________________ ______________

Legal Guardian #1 Signature **Date**

______________________________________ ______________

Legal Guardian #2 Signature **Date**

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CLIENT QUESTIONNAIRE

Please complete as much of this information as possible and give this form to your health care provider at your first visit. Please note that if the provider you are seeing is on your insurance panel, we must have a copy of your current insurance information prior to your first visit. Some insurance companies will not cover your visit if it has not been pre-certified. Please make every effort to know and understand your mental health insurance benefits prior to your visit(s) to LifePointe Counseling, LLC.

Name: ______________________________ **Date:** ______________

Please give us a brief description of your need for counseling:

____
____
____
____

Please answer the following questions by circling either Yes or No. If Yes, please provide a brief description of the problem area:

Anxiety/Stress – Yes or No

____
____

Uncomfortable in Social Settings – Yes or No

____
____

Compulsions/Addictions – Yes or No

____
____

Appetite Changes – Yes or No

____
____

Sleep Changes – Yes or No

____
____

Concentration/Focus Problems – Yes or No

____
____

Work/School Impairment – Yes or No

____
____

Difficulty Caring for Self/Family/Home/Children – Yes or No

____
____

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CLIENT QUESTIONNAIRE *(continued)*

Family Conflicts – Yes or No

____

____

Spiritual Problems – Yes or No

____

____

Depression – Yes or No

____

____

Feelings of Hopelessness/Despair – Yes or No

____

____

Self-Harm – Yes or No

____

____

Suicidal Thoughts – Yes or No

____

____

Suicidal Plans – Yes or No

____

____

Suicidal Attempts – Yes or No

____

____

Previous Hospitalization – Yes or No

____

____

Previous Counseling – Yes or No

____

____

Current Counseling – Yes or No

____

____

Medication History (List **current** medications here, and provide your complete history on separate page)

____

____

____

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THOROUGH MEDICATION HISTORY

Medication Name (Please Include Dosage/Mg)	Date(s) Prescribed/Taken	Side Effects

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NOTICE OF 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 HEALTH INFORMATION IS IMPORTANT TO US.

From time to time, LifePointe Counseling LLC uses and discloses confidential personal information about patients. We know this information is private. We call this information "protected health information" (PHI). We are required by applicable federal and state law to protect the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. This notice describes how we may use and disclose your PHI and certain rights you have with respect to your PHI. This notice takes effect June 1, 2018 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and, as applicable law permits, the terms of this notice at any time, reflecting such changes.

You may request a copy of our notice at any time. For any information about our privacy practices or for additional copies of this notice, please contact our office at the address or number listed below.

USES AND DISCLOSURES OF HEALTH INFORMATION

HIPAA privacy rules permit us to use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below.

FOR TREATMENT: We may use or disclose PHI about you to coordinate your health care. We may consult with other health care providers who are involved in your health care. For example, your PHI may be shared by your therapist, primary care doctor and psychiatrist to coordinate a plan for your treatment.

FOR PAYMENT: We may use or disclose information to get payment for the health care services you receive. For example, we may provide PHI to bill your health plan for services provided to you.

FOR HEALTHCARE OPERATIONS: We may use or disclose information in performing business activities for which we call "healthcare operations". Examples would be quality assessments, reviewing the competence and performance of our staff, etc. This allows us to improve the quality of care we provide.

APPOINTMENTS AND OTHER HEALTH INFORMATION: We may use or disclose your PHI to provide you with appointment reminders for medical services/appointments (such as voicemail, letters, etc.). We may send you invoices for additional payments due after processing your insurance claims. We may also send mailings from time to time regarding other services that we feel might be of interest to you.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by federal or state law. If federal or state law creates higher standards of privacy, we will follow the higher standard. (Examples: a court order, a request from the Social Security Administration, etc.).

FOR ABUSE REPORTS AND INVESTIGATIONS: If we reasonably believe that a patient, a minor, a dependent adult, and/or the elderly have been a victim of abuse or neglect, domestic violence or a crime, we may disclose PHI as required by your state of residence, or the state where the alleged incident(s) has been reported. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety, or the safety or health of others.

NATIONAL SECURITY: We may disclose to military authorities the PHI of military personnel, and military contractors, under certain circumstances. We may disclose to authorized federal officials any PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or local/state/federal law enforcement official having lawful custody of protected PHI of inmate or patient under certain circumstances.

YOUR AUTHORIZATION: In addition to our use of your PHI for treatment, payment, healthcare operations or appointments, you may give us written authorization to use your PHI, or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your PHI for any reason except those described in this document.

TO YOUR FAMILY/FRIENDS OR PERSONS INVOLVED IN YOUR HEALTHCARE: We must disclose your PHI to you, as described in this document. We may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree in writing that we may do so.

TO PERSONS INVOLVED IN YOUR CARE: We may use or disclose your PHI to notify, or assist in the notification of a family member, your personal representative, legal guardian, or another person responsible for your care, of your location, your general health, or other circumstances deemed necessary. If you are present, we will provide you with an opportunity to object to such uses or disclosures prior to the use or disclosure of your PHI. In the event of your incapacity or emergency circumstances, we will disclose PHI based on determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with behavioral health practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies/devices/supplements, documentation, etc., or some other form of PHI.

YOUR PATIENT RIGHTS

RIGHT TO INSPECT AND COPY MEDICAL RECORDS: In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be asked to make an appointment with your provider to go over the records and you may be charged a fee for the cost of copying your records. Records will not be mailed via general mail delivery. If you want your records mailed, you will be charged the cost of sending them via registered/certified mail. If your files are in our offsite storage facility, there is a minimum $25 fee for staff time to travel, locate and copy your PHI. If you require a letter summarizing or explaining your PHI, please talk to your provider regarding their fees for this service.

RIGHT TO REQUEST RESTRICTIONS: You have the right to ask us to limit how your information is used or disclosed. You must make this request in writing and tell us what information you want to limit and to whom you want the limits to apply. We are not required to agree to this limit. You can request in writing that the limit be terminated.

RIGHT TO AMEND: You may ask us to change or add missing information to your records if you think there is a mistake. You must make the request in writing and provide a reason for your request. We may deny your request under certain circumstances.

RIGHT TO FILE A COMPLAINT: You have the right to file a complaint with us at the address printed below and with the Secretary of the United States Department of Health and Human Services if you do not agree about how we have used or disclosed information about you.

RIGHT TO REVOKE PERSMISSION: If you are asked to sign an authorization to use or disclose your PHI, you may cancel that authorization in writing at any time. This will not affect information that's already been shared.

RIGHT TO CHOOSE HOW WE COMMUNICATE WITH YOU: You have the right to ask that we share information with you in a certain way or in a certain place. For example, you can ask us to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the reason for your request. You must provide a satisfactory explanation of how payments will be handled under alternative means or location you request.

RIGHT TO RECEIVE NOTICE OF CHANGE TO PRIVACY STATEMENT: You have the right to receive notice of changes in our privacy statement that affect you or after the effective date of the change. Please note that all changes will be posted on our website, but you may still request a written copy of same.

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QUESTIONS AND COMPLAINTS

If you want more information or explanation of our privacy practices, or you have any questions or concerns, please contact us.

As a Christian counseling agency, we respectfully request that clients follow the dispute resolution process exemplified for us in Scripture, specifically in Matthew 18. Please know that you have recourse if you feel that your privacy protections and/or rights have been violated. If you feel that your health care provider and/or other LifePointe Counseling, LLC staff member have wronged you, we request that you first go to that person and respectfully communicate your grievance(s) in an attempt to resolve the situation between the two of you. If the issue cannot be resolved between the two of you, we then recommend contacting LifePointe Counseling, LLC's President to coordinate a group meeting with you, the company President, and the staff member involved in your complaint. If you feel your matter is still not resolved following a group meeting with LifePointe Counseling, LLC's President, you may pursue further recourse at your discretion.

You have the right to file a written complaint with our office, the Department of Health & Human Services, your healthcare provider's licensing board, or with the Office of Civil Rights about violations of the provision of this Notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. We will provide you with the address to file your complaint with the U.S. Department of Health & Human Services upon request. You may submit your complaint to us using the contact information listed at the end of this Notice.

We support your right to the privacy of your health information.

Contact Officer: Office Manager

Telephone: 314-849-2120

Fax: 314-729-1953

Address: LifePointe Counseling, LLC
11166 Tesson Ferry Road, Suite 203
St. Louis, MO 63123