LFCS
Lutheran Family and Children's Services of Missouri
One Promise. One Family.

CONSENT FOR TREATMENT FORM

Welcome to Lutheran Family and Children's Services. LFCS provides individual, couples and family counseling. In this regard, LFCS provides services to persons in need regardless of religion, ethnicity, gender, sexual orientation or disability. You have the right to be treated with dignity and respect, and we are committed to this principle. Our statement of *Client's Rights and Responsibilities* is posted in our waiting area and we will be happy to provide you with a copy if you would like one.

In order to evaluate the quality of our program, you may periodically receive a satisfaction survey from LFCS. You can receive the form via email. See the Acknowledgements and Signatures page of this document.

STATEMENT ON CONFIDENTIALITY

LFCS values and protects your confidentiality. This means that information shared between the client and the therapist or any other LFCS staff remains private and is protected health information. Your health information may be shared for the purpose of a case audit by a funding source or accrediting agency or securing payment for services on your behalf, such as insurance, Medicaid, Medicare or other funders. As a new client at LFCS you will receive a Notice of Privacy Practices and a Telehealth Notice, which explain these policies and procedures in detail. Please ask your therapist about anything that is unclear to you. Exceptions to confidentiality include any report of harm to self, harm to other or that someone else has harmed you.

COUNSELING PLAN AND INFORMED CONSENT

It is important for you to participate with your therapist in defining your goals for treatment and in formulating a plan for working towards those goals, which is the Treatment Plan/Service Plan. If we feel additional help would be beneficial, we may offer referrals for you or your family, either within LFCS or to another agency. You have the right to refuse any therapeutic intervention that you do not want to receive. The counselor may also choose to refer you to a different resource if he/she feels your non-compliance with the treatment plan may be detrimental to your well-being.

LFCS is a hands-off agency and restrictive physical contact or behavior management techniques are not used by LFCS therapists. There are no known negative side effects to counseling.

SOCIAL SECURITY/DISABILITY CLAIMS/CUSTODY CLAIMS

LFCS counseling services are intended solely for the treatment of the client. The client agrees and understands that LFCS therapists do not provide copies of a client's records or treatment summaries in support of Social Security, Disability or Custody claims or disputes. Information regarding services provided is not for secondary use or release. By signing this consent form, client waives right to subpoena therapist's appearance or copies of record for purposes of custody claims. In the event that a therapist is required to testify for any reason, the client agrees to pay fees of $150 per hour to the agency.

COMPLAINT

You have the right to lodge a complaint by contacting the Director of Behavioral Health at 787-5100. You may also file a formal written grievance to our main office at 9666 Olive Blvd, Suite 400, St. Louis, MO 63132.

→ OVER

FEE INFORMATION

Counseling fees at LFCS are $105.00 per fifty-minute session. LFCS accepts most major insurance plans; offers a sliding fee scale and offers grant funding as available.

INSURANCE AND MANAGED CARE FEES

If you use insurance for your counseling, we will release only the information necessary for your insurance company to facilitate payment.

If your insurance is handled through a managed care company or a managed Medicaid/Medicare plan, you will need to have pre-authorization (pre-certification) prior to your first appointment. It is your responsibility to assure that services remain within the limits of this authorization; otherwise, you are responsible for the fee. You are responsible for any deductible amount your insurance may have.

SLIDING SCALE FEES

For those not using insurance, LFCS applies a sliding scale based on the family income and the number of persons in the family. Sliding scale fees are subsidized by financial gifts to LFCS and other funders such as United Way. The actual cost to LFCS for each hour of counseling is $105.

Any credit balance in a client's account will be applied to payment for future sessions used by the client. Credit balances remaining at the end of a calendar year or upon termination of counseling services will be considered to be a donation to Counseling Assistance Fund unless reimbursement is requested by the client. Client donations in excess of the client's designated fees will also be applied to CAF.

CANCELLATIONS AND/OR FAILURE TO KEEP APPOINTMENTS

A fee will be charged for appointments you fail to keep and that are not canceled 24 hours in advance. All counselors have voice mail so that you can leave a message at any time should you need to reschedule. Please provide your counselor with a daytime contact number to use should the counselor need to reschedule your appointment.

Your fee or co-pay is _____ and is payable at each session.

SIGNATURES AND ACKNOWLEDGEMENTS

My signature below indicates that I have read and understand the above information. My signature also confirms that I have received and reviewed **the Telehealth Notice, the Notice of Privacy Practices and the Commitment to Quality**. I understand my rights relative to the use of my protected health information. My signature serves as consent to treatment. I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth session.

_____ _____

Client/ Parent or Guardian Signature Date

My signature below indicates permission to release necessary information to my insurance in order to process my claim and to send payment directly to LFCS.

_____ _____

Client/ Parent or Guardian Signature Date

LFCS cannot guarantee the security of information exchanged via electronic communication.

- I agree_☐_ or do not agree_☐_ (please check one) that the LFCS Therapist may communicate with me/us about my case or my child's case via e-mail or other electronic communication system, including telehealth sessions. I understand that electronic communication may not be secure and I have reviewed the Telehealth Notice.

- I agree_☐_ or do not agree_☐_ (please check one) that the LFCS Therapist may communicate with me/us and that information may be exchanged about my case or my child's case by other means of electronic communication system (i.e. texting or voice mail). I understand that texting and voice mail may not be secure and that my therapist and I will not share confidential information via text or voice mail.

- I agree _☐_or do not agree _☐_ (please check one) to receive LFCS client satisfaction surveys via e-mail year. E-mail address: _____

Lutheran Family & Children's Services of MO, 9666 Olive Blvd, Suite 400, St. Louis, MO 63132
(314)-787-5100

MEDICATION LIST

Lutheran Family & Children's Services

Name:	Date:

(Include Over the Counter Meds & Supplements)

Name of Medication or Supplement (vitamin, calcium, etc)	Dosage	Frequency/Directions	Route (oral, IV, injection)	Physician Prescribing	Condition

☐ **None**

_____

Parent/Guardian/Adult Client Signature

_____ **Date**

_____ ***** For office use only***** _____

Medication information received from:

☐ **School Nurse**

☐ **Obtained Verbally From Parent/Adult Client**

_____ _____

Therapist signature: **Date:**

Counseling Department Cancellation/No Show Policy

Dear Client,

As you may recall, the following statement appeared on your initial Informed Consent Form:

"A fee will be charged for appointments you fail to keep and that are not canceled 24 hours in advance. All counselors have voice mail so that you can leave a message at any time should you need to reschedule your appointment. "

We have reviewed the above policy and have determined that a fee of $15 will be billed to clients who fail to show for an appointment or who do not inform their counselor of their inability to keep an appointment at least 24 hours in advance of the scheduled time.

Should an emergency or an urgent situation arise that prevents you from keeping an appointment and makes it impossible for you to cancel 24 hours in advance, please let your counselor know about this as soon as you are able. This policy will go into full effect on January 2, 2012.

Thank you for your understanding and for allowing us the privilege of serving you.

Sincerely,

Director of Counseling

DATE: _____

Client/Guardian: _____

Apricot #: _____

Witness: _____

Child/Youth Rights and Responsibilities

Working with a therapist can help you make changes in your life. You can work on anything that you want to improve. Your Therapist will meet with you at a time that works for you and your family.

During Counseling, you have the right to:

- Set your own goals
- Help decide how you work on your goals
- Confidentiality – What is said in counseling will not be shared with anyone without your permission unless you tell your therapist that you are being hurt by someone or that you want to hurt yourself or someone else or that you are doing something that is against the law
- Learn about yourself and freely express your feelings and opinions in a safe place.

During Counseling, you have the responsibility to:

- Help make decisions
- Practice new skills (Participate)
- Cooperate
- Be honest

*If you choose to not cooperate and honestly participate, your therapist may decide it is not possible to meet with you, either for one session or entirely.

Steps if you are unhappy with Counseling:

1. Tell your family and your therapist honestly about why you are unhappy
2. Tell your therapist's Boss
3. Tell their boss's boss and so on including telling the President of LFCS (if necessary)

By signing this form you are saying that you understand what Counseling is, what rights and responsibilities you have, and how you can let someone know if you are unhappy with Counseling.

_____ _____

Signed Date

_____ _____

Witness Date

Adverse Childhood Experience (ACE) Questionnaire
Staff Completing with Child (ages 5-9)

Lutheran Family & Children's Services

Today's Date: Child's Name:

The following questions are for young children who either cannot read or may not understand the content of the questions. Please read the questions to the child using the clarifying questions as a guide to help them better answer the questions accurately.

1) Did you live with anyone who was depressed, mentally ill, or suicidal? *Alternative question: Does anyone you live with cry a lot, seem really sad, tried to hurt themselves, or has gone to the hospital feeling very sad or upset? Do they take any medications? Do you know what they take medications for?*	☐ Yes ☐ No ☐ Don't know/Not sure
2) Did you live with anyone who was a problem drinker or alcoholic? *Alternative question: Does anyone you live with drink beer, wine, or hard liquor? If yes, how much and how often?*	☐ Yes ☐ No ☐ Don't know/Not sure
3) Did you live with anyone who used illegal street drugs or who abused prescription medications? *Alternative question: Does anyone you live with take any kind of drugs or medicine that they didn't get from a doctor?*	☐ Yes ☐ No ☐ Don't know/Not sure
4) Did you live with anyone who served time or was sentenced to serve time in prison, jail, or other correctional facility? *Alternative question: Do you live with anyone who spent time away in prison or jail (a.k.a. locked up)?*	☐ Yes ☐ No ☐ Don't know/Not sure
5) Were your parents separated or divorced? *Alternative question: Were your parents married?*	☐ Yes ☐ No ☐ Parents never married ☐ Don't know/Not sure
6) How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
7) Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking. *Alternative question: If yes, what did they do and when?*	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
8) How often did a parent or adult in your home ever swear at you, insult you, or put you down? *Alternative question: Do your parents or an adult at home ever cuss at you, insult you, or put you down making you feel like you're not important or special?*	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
9) How often did anyone at least 5 years older than you or an adult, touch you sexually? *Alternative question: Has anyone ever touched you anywhere that would be covered by a swimsuit? Were they older than you? How much older?*	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
10) How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually? *Alternative question: Has anyone ever made you try to touch them anywhere that would be covered by a swimsuit? Were they older than you? How much older?*	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
11) How often did anyone at least 5 years older than you or an adult, force you to have sex? *Alternative question: Based on answers to 9 or 10, have the child describe what happened?*	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure

Adverse Childhood Experience (ACE) Questionnaire
Parent/Guardian Completing for Child (ages birth-10)

Lutheran Family & Children's Services

Today's Date: Child's Name: Your Name:

The following questions are about events have happened during your child's life. This information will allow us to better understand problems that may occur early in life, and may help others in the future. This is a sensitive topic and some people may feel uncomfortable with these questions. Please keep in mind that you can skip any question that you do not want to answer. All questions refer to the time period before your child was 18 years of age. Please check ✓ the appropriate response.

1) Does your child live with anyone who was depressed, mentally ill, or suicidal?	☐ Yes ☐ No ☐ Don't know/Not sure
2) Does your child live with anyone who was a problem drinker or alcoholic?	☐ Yes ☐ No ☐ Don't know/Not sure
3) Does your child live with anyone who used illegal street drugs or who abused prescription medications?	☐ Yes ☐ No ☐ Don't know/Not sure
4) Does your child live with anyone who served time or was sentenced to serve time in prison, jail, or other correctional facility?	☐ Yes ☐ No ☐ Don't know/Not sure
5) Are your child's parents separated or divorced?	☐ Yes ☐ No ☐ Parents never married ☐ Don't know/Not sure
6) How often do/did your child's parents or adults in their home ever slap, hit, kick, punch, or beat each other up?	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
7) Before age 18, how often did a parent or adult in your child's home ever hit, beat, kick, or physically hurt your child in any way? Do not include spanking.	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
8) How often did a parent or adult in your home ever swear at your child, insult your child, or put your child down?	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
9) How often did anyone at least 5 years older than you or an adult, touch your child sexually?	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
10) How often did anyone at least 5 years older than your child or an adult, try to make your child touch them sexually?	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure
11) How often did anyone at least 5 years older than your child or an adult, force your child to have sex?	☐ Never ☐ Once ☐ More than once ☐ Don't know/Not sure

LUTHERAN FAMILY AND CHILDREN'S SERVICES
CHILDREN & YOUTH CLIENT INFORMATION

Name:
Date:

The information that you write down on this form will assist the work you and your counselor will be doing together. The Client Information Form will become part of your record at LFCS and will be protected by the Agency's Statement of Confidentiality. Please answer these questions, as you are comfortable and willing at this time.

1. Briefly state the problem(s) that brought your family to counseling at this time.

Please rate your family's current situation.
(0-10; 0 - worst, 10 - best)

2. What goals would you like your family to accomplish through counseling?

3. What strengths or positive assets (personal, family, spiritual, or community) does your family bring to your situation?

PLEASE CIRCLE THE ANSWERS TO THE FOLLOWING QUESTIONS

- Is a doctor currently treating your child for any physical problems? YES NO
- Is your child currently taking any medication for these physical problems? YES NO
- Is your child experiencing physical problems for which s/he is not being treated? YES NO
- Does your child use tobacco? YES NO
- Has your child ever used counseling or other mental health services before? YES NO
- Has your child's school identified any special learning problems? YES NO
- Is your child currently taking any medication for emotional problems? YES NO
- Has your child ever received treatment for alcohol or drug abuse? YES NO
- Does your child have more than two alcoholic drinks per day? YES NO
- Does your child exercise at least three times per week? YES NO

↻ OVER PLEASE

Parents/Guardians - Please list your child's parents

Mother: _____ Father: _____

Married to each other ☐ Separated from each other ☐ Divorced from each other ☐

Never married to each other ☐

Who has Custody? _____

Emergency Contact: _____ _____
(Name) (Phone #:)

School

School: _____ Grade: _____ Phone #: _____

Teacher: _____ School Counselor: _____

Health History

Family Physician (or Pediatrician) Name: _____ Phone #: _____

Psychiatrist Name: _____ Phone #: _____

Date your child began treatment: _____

If your child is currently taking any prescription medications, please list them:

	MEDICATIONS	**DOSAGE**	**PRESCRIBING PHYSICIAN**
1.	_____	_____	_____
2.	_____	_____	_____

PLEASE CIRCLE ALL ANSWERS THAT APPLY TO THE FOLLOWING QUESTIONS

Has there been any incidence of the following with your child or your family?

- Verbal Abuse? . . . . . PAST☐ PRESENT☐ NEVER☐
  Who was abused? _____
  Who was the abuser? _____
- Physical Abuse? . . . . . PAST☐ PRESENT☐ NEVER☐
  Who was abused? _____
  Who was the abuser? _____
- Sexual Abuse? . . . . . PAST☐ PRESENT☐ NEVER☐
  Who was abused? _____
  Who was the abuser? _____
- Alcohol or Drug Abuse? . . . . PAST☐ PRESENT☐ NEVER☐
  Who? _____
- Suicide Attempts? . . . . . PAST☐ PRESENT☐ NEVER☐
  Who? _____ When? (date/s):_____
  Who? _____ When? (date/s):_____

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TELEHEALTH CONSENT NOTICE

Telehealth is healthcare or mental health services provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for assessment, consultation, treatment, therapy, follow up and education. Information is exchanged interactively from one site to another through electronic communication. Telephone consultation, video conferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

You have the right to withdraw consent at any time without affecting your right to future care, services or program benefits to which you would otherwise be entitled.

Telehealth billing information is collected in the same manner as a regular home, school or office visit. If your sessions are paid for by your insurance, your financial responsibility will be determined individually and governed by your insurance carrier(s) and it is your responsibility to check with your insurance plan to determine coverage.

There are risks, benefits and consequences associated with telehealth services, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality to unauthorized persons, and/or limited ability to respond to emergencies.

There will be no recording of any kind of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law or funder.

All electronic communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

• It is easier for electronic communication to be forwarded, intercepted, or even changed without your knowledge and despite taking reasonable measures.

• Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for you to use a secure device and network.

• Despite reasonable efforts on the part of your healthcare provider, the transmission of information could be disrupted or distorted by technical failures.

<u>BENEFITS:</u>

- Client/family do not need to have transportation to participate in sessions.
- Convenient scheduling of appointments.
- Client/family may choose the best technology for their situation whenever feasible.
- Easy access to services within client/families home.
- Comfort of working with the same LFCS staff.

- Staff are qualified to provide service and follow best practices guidelines.
- Funding options for services remain the same (ex: low cost, no cost, insurance)

LIMITS AND RISKS:

- Confidentiality may be limited based on communication method chosen and location of client during session or consultation.
- Unsecured video or internet-based communication technology is less secure than telephone.
- Privacy within a client's family may be limited at times.
- The therapist, psychiatrist or social worker will provide information regarding their location and make every effort to prevent any potential for interruption.

The privacy laws that protect the confidentiality of protected health information (PHI) also apply to telehealth services unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse, a danger to self or others, subpoenaed for a legal proceeding or requested by a funder, including insurance).

For the sake of privacy, your mental health provider will not use SMS or MMS texting with clients, except in limited circumstances for scheduling.

Client responsibilities:

- Verify your identity with the mental health provider and share current location in connection with the telehealth services. A picture ID may be requested to verify your name and identity. This process protects you from another person posing as you.
- You have a responsibility to verify the identity and credentials of the mental health provider rendering care via telehealth and to confirm that he or she is your provider.
- Understand that electronic communication cannot be used for emergencies or time sensitive matters. If you are having suicidal or homicidal thoughts, actively experiencing psychiatric symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is necessary.
- When an immediate response is necessary due to an emergency situation, you may call Behavioral Health Response 314-469-6644, which offers professional service 24 hours a day. You may also seek help through hospital emergency facilities or calling 911.
- During a telehealth session, technical difficulties resulting in service interruptions may occur. The most reliable backup is a phone. Therefore, it is recommended that you always have a phone available and that your mental health provider knows your phone number. If you get disconnected from a video conference, you may end and restart the session. If you are unable to reconnect within five minutes, call your provider. If your provider does not hear from you within five minutes you agree (unless you request otherwise) that your provider can call you on the phone number you provide on the client intake form. If you and your provider are unable to connect via the phone, they will send you a message via email to reschedule your session.

OUR MISSION

Through Christ's love, we empower children and families to overcome challenges today so they can build a better tomorrow.

OUR VISION

Generations of children and families across Missouri are safer and stronger together.

OUR COMMITMENT

Our commitment is to serve families and children throughout the State of Missouri in a quality manner To this end, we ask ourselves the critical questions:

- Are we effective in getting results?
- What are the challenges we face?
- How can we do better?

These questions help guide our activities and improve on the systems that support our day-to-day operations.

The approach of LFCS to service delivery is strength based and collaborative, promoting respect and positive behavior in a safe and secure environment. We access potential clients for appropriateness of service and may refer to other resources to best meet the needs of the client

If you have any questions about this notice or concerns regarding our privacy practices, please contact:

Privacy Officer • St. Louis Office
9666 Olive Boulevard, Suite 400
St. Louis, MO 63132
314-787-5100 • 1-866-326-5327

Mid-Missouri
307 Locust Street
Columbia, MO 65201
573-815-9955

St. Charles
100 Piper Hill Drive
St. Peters, MO 63376
636-949-5522

Southeast Missouri
3178 Blattner Drive
Cape Girardeau, MO 63703
573-334-5866

Southwest Missouri
2130 N. Glenstone Avenue
Springfield, MO 65803
417-862-1972

Hilltop Child & Family Development Center
6155 West Florissant Avenue
St. Louis, MO 63136
314-389-1001

Franklin County
500 Clark Ave
Union, Missouri 63084
636-234-0893

LFCS
Lutheran Family and
Children's Services of Missouri

314-787-5100 or 1-800-326-LFCS (5327)
If interested in learning more about our services, volunteering, or making a donation to LFCS, call or visit our website
www.lfcsmo.org

PRIVACY PRACTICES

Notice of Privacy Practices

Revision Date: August 2019

LFCS
Lutheran Family and
Children's Services of Missouri

NOTICE OF PRIVACY PRACTICES

This policy is developed in compliance with the Health Insurance Portability and Accountability Act of 1996 (45 CFR) (HIPAA). If you are a client of Lutheran Family and Children's Services of Missouri, this notice describes how your health information may be used and disclosed, and how you can get access to this information. Please review this notice carefully. A full copy of this notice is available upon request.

I. Understanding Your Health Information

As a client of Lutheran Family and Children's Services of Missouri (LFCS), or other health care providers, a record is kept of your visit. This record, typically referred to as a case record, contains your reason for seeking services, symptoms, diagnosis, and plan of treatment for future services. Although the case record is the property of LFCS, the information within the record belongs to you This information is considered your "Protected Health Information" (PHI) and is afforded certain protections under the law.

II. How- We Can Use Your Health Information:

- Service
- Payment
- Duty to Warn
- Public Health
- Private Support
- Emergencies
- Health Care Operations
- Charges Against the Agency
- Requirements by law
- Other with notification

LFCS will release only the minimum amount of information necessary to address the purpose of the use or disclosure. In any other situation, LFCS will request your written authorization before using or disclosing any of your identifiable health information. If you choose to sign such an authorization to disclose information, you can revoke that authorization at any time to stop future uses/disclosures

III. Your Rights Regarding Your Health Information

You have the following rights with respect to your protected health information:

- request in writing that your protected health information not be used or disclosed by LFCS for treatment, payment or administration purposes or to persons involved in your care except when specifically authorized by you The agency will consider your request, but we are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

- request that we contact or send you information at an alternative address or by an alternative means. We will agree to your request as long as it is reasonably easy for us to do so.

- inspect and copy your protected health information Any such requests must be made in writing. The agency will respond in writing to such a request within 30 days. If you request copies, LFCS may charge you a reasonable cost for copying.

- submit a request to amend your information if you believe that information in your record is incorrect or if important information is missing.

- an accounting of disclosures of your protected health information.

You have a right to receive this Notice in paper and/or electronic format.

IV. The Agency's Duties

LFCS is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

LFCS is required to abide by the terms of this Notice currently in effect, and LFCS reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. Should the agency make changes in its Notice, 1t will post the changed Notice in its office waiting areas and on our website. You may request a copy of the Notice at any time.

V. Complaint Procedure

If you are concerned that LFCS may have violated your privacy rights, or you disagree with a decision LFCS made about access to your records, you may contact the person listed below. You may also send a written complaint to the Secretary of the Department of Health and Human Services. The person listed below con provide you with the appropriate address upon request. Under no circumstances will any actions be token against you for filing a complaint.

Privacy Officer
9666 Olive Blvd, Suite 400
St. Louis, MO 63132
(314) 787-5100 • 1-866-326-5327