Family Service Association of Greater Elgin Area

Client Fee Agreement

As a nonprofit community agency, Family Service Association has various sources of funding. These sources include United Way, local tax moneys, benefactors and State and Federal sources. However, this support does not cover the full cost of providing counseling services and therefore we must charge a fee for our services.

For your information, the following is our fee schedule and fee collection policy.

1. Fees: The agency fees are as follows:

   Case Management
   - Client Centered Consultation Services
   - Case Management Services
   - Family and Community Support Services
   - Therapy Services
     - Individual/Couple/Family/Group Counseling
     - Mental Health Assessment
     - Treatment Planning
     - Fitness Restoration Services
   - Psychiatric Services
     - Psychiatric Evaluation Services
     - Medication Monitoring Services

   Case Management: $65.00 per hour
   Therapy Services: $120.00 per hour
   Psychiatric Services: $240.00 per hour

At the initial comprehensive assessment appointment, the therapist will review this fee policy with you.

2. Fee Subsidy: If you cannot afford the fee, you may qualify for a subsidized fee based on our client subsidy fee scale. Under these circumstances, the agency will ask you to provide further verification of your income and expenses. Your therapist will discuss with you our Fee Adjustment through our Consumer Credit Counseling Service.

3. Cancellations: If you must cancel an appointment please notify your therapist at the earliest possible time, but no later than 24 hours prior to your scheduled appointment. If the appointment is cancelled with less than 24-hour notice, the cancellation charge is $25.00. You will automatically be charged the cancellation fee if you fail to keep an appointment without notifying the agency(except due to emergency situations). Any cancellation fees must be paid prior to attending your next appointment.

4. Payment: Payment is expected at the time services are rendered, including the assessment session. Fees may be paid by cash or check. If fees are paid in cash, you are asked to have the exact amount. If a check is returned

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due to insufficient funds, you will be required to pay in cash after the first such occurrence. On occasions where services are provided away from our offices, you will be billed on a monthly basis. Full payment is expected within 30 days. Please discuss any circumstances surrounding unpaid balances with your therapist.

5. Insurance:

Depending on your health insurance coverage, our agency may file a claim with your insurance carrier. You may be responsible for your “per session” payment regardless of what your insurance pays. You must make regular fee payments, per your fee agreement, regardless of what payments you expect from your insurance company. We will bill your insurance carrier at the full rate for the services you receive. Most insurance policies pay a percentage of our agency fee. If the amount paid by you, plus the amount received from your insurance company totals more than the full cost of service, a direct payment refund will be made to you. Family Service Association seeks only to collect the full cost of providing services.

If your third party benefits have been exhausted, your therapist will assist you in setting a sliding fee scale. This sliding fee scale will remain in place until your third party benefits resume, at which time the agency will begin billing your insurance carrier.

When our agency submits a claim to your insurance carrier, the following standard information will appear on the claim form: 1) Name and address of the insured and the name and address of the person receiving service. 2) Social security number, group and/or individual policy ID number. 3) Psychiatric diagnosis (DSM IV). 4) A list of appointment dates, services provided, and the fee charged for the service. This information will be available for filing with your insurance carrier for up to one year after our services are terminated. Any of the above information requested by your insurance carrier after this one year period will not be released until an updated consent form is signed by the recipient of services.

6. Annual Review:

It is the policy of this agency to review our subsidy structure, rates and fees on an annual basis. Changes resulting in fee review go into effect with minimally 60 days notice. This review may mean an adjustment in your fee. Anytime there will be a fee adjustment as a result of the review, you will be notified prior to the adjustment taking effect.

Any questions regarding the fee policy, or changes in your financial situation during the course of therapy, can and should be discussed with your assigned clinician.

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Policy and Procedures

Title: Behavior Management Policy

Purpose: To assure that all agency personnel utilize appropriate behavior management interventions with the oversight of the management team and agency Board of Directors. The use of restrictive behavior management interventions is in compliance with all federal, state and local legal and regulatory requirements, to insure a client's physical safety.

Policy: The agency allows the use of manual restraint (a procedure in which a client is prevented from moving his/her limbs and/or body for a period of time) by a qualified staff and only in the event of an emergency. An emergency is one in which a client may display self-injurious behavior, may place themselves in a position of physical danger, may be aggressive with others or may be non-compliant with directives intended to prevent injury to a client. Manual restraint is used only after less restrictive behavior management techniques have failed. In all cases, a minor's parent is expected to control their child. In emergency situations, staff may assist if the parent/guardian is unable to keep the minor/others safe. Additional behavior management interventions that may be utilized include:

- Positive reinforcement designed to increase targeted behavior
- Ignoring non-dangerous behaviors while working on the extinction of those behaviors
- Redirection of behavior or removing client from area in which problematic behavior is occurring
- Working with client to regain control including the use of relaxation techniques.

The following practices are prohibited:

- Chemical restraint
- Isolation or Locked seclusion
- Mechanical restraint
- Aversive Stimuli
- Excessive or inappropriate use of restrictive behavior management
- Restrictive behavior management that is in response to property damage that does not involve imminent danger to self or others.

In the event that the use of manual restraint is necessary to protect a client from hurting themselves or others, staff should use as little force as possible. Manual restraint is never to be used as punishment or as a discipline technique. The agency discontinues the use of manual restraint as soon as possible and/or if it produces adverse side effects, such as illness, severe emotional or physical stress, or physical damage. Persons manually restrained are to be continuously monitored and restraint should last no longer that 15 minutes. If a client presents with behavior that requires potential for more that 15 minutes of restraint, alternative strategies would be employed. These may include parental assistance or contacting emergency response personnel or police. If the restraint does exceed 15 minutes, a Licensed Practitioner of the Healing Arts (LPHA) will be consulted for reauthorization of the restraint.
Procedure:

- All employees of the agency will be required to sign an agreement form to be placed in the employee personnel file acknowledging that they have read this policy and agree to the terms.
- Failure to comply with this policy may result in termination or other disciplinary action.
- During the assessment process, determination is made regarding each client’s potential need for a behavior management plan based on the client’s potential risk of harm to self or others.
- All persons served and/or guardians will receive a copy of the Discipline and Behavior Management policy and procedures.
- If it is determined that a client is in need of a behavior management plan, this will be incorporated in the client Individual Treatment Plan.
- All incidents in the use of physical restraint with a client and the clinical justification circumstances and efforts to employ less restrictive measures must be documented in a client’s chart and an agency incident report filed within 24 hours with the Clinical Director.
- Parents/guardians of clients will be notified immediately if manual restraints were utilized during any program services.
- Debriefing will be offered and will occur within 24 hours in a safe and confidential setting and should include the client, all appropriate personnel and the parents/guardians.
- The debriefing process will include an evaluation of the physical and emotional well being of all involved, identify the need for medical care, counseling or other services related to the incident and facilitate the reentry to services. The debriefing will also include an evaluation of the incident, identification of behaviors leading up to the incident, discussion on how the incident was handled, necessary changes to procedures and/or training to avoid future incidents and the modification of the Individual Treatment Plan as necessary.
- Following each use of manual restraint, the incident will be reviewed by the administrative team and recommendations for further actions will be made as needed.
- All incident reports related to restrictive behavioral management interventions are shared at the Governing Board of Directors monthly meetings. The Executive Director will inform the Governing Board of Directors what actions, if any, were taken regarding the incident.
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions, please contact the Privacy Officer at the address/phone number above. All written requests or appeals should be submitted to the Privacy Officer.

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat You
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information such as if you have Medicaid. All information is required to be shared for Medicaid recipients.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will
follow your instructions. We do not sell or market your information. We do not maintain hospital directories and are not associated with a hospital.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission or it is an emergency:

- Substance abuse information
- Mental Health records
- A youth age 12 and older also needs to consent (in addition to their guardian) for the release of their mental health or substance abuse information.

We may contact you for fundraising efforts, but you can tell us not to contact you again.

### Our Uses and Disclosures

#### How do we typically use or share your health information?

We typically use or share your health information in the following ways:

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

#### How else can we use or share your health information?

We may disclose your health information to our business associates, each of whom has entered into a written contract with us regarding the privacy of your health information.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications
- Helping with product recalls
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research, but it is our policy to ask your permission before doing this.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services and Department of Healthcare and Family Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
• For workers' compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Other uses of health information
In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing health information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing. However, we cannot take back any disclosures already made with your permission, and must keep records for your care.

Our Responsibilities
• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website www.fsaelgin.org.
Statement of Rights


You shall not be denied, suspended, or terminated from services or have services reduced for exercising any of your rights.

This agency is committed to offering professional and humanistic services directed toward your needs in a manner that protects your dignity and feelings of self worth.

CIVIL RIGHTS
1. You have the right to be treated with dignity and respect.
2. You have all rights, benefits, and privileges guaranteed by law.
3. You have the right to be free from abuse, neglect, and exploitation.
4. You have the right to be provided mental health services in the least restrictive setting.

DISCRIMINATION
1. Services will be provided to you/your family members without discrimination. Ethnic background, personal or social creed, racial membership, sex, religion, or age will not affect our services to you.
2. You will not be refused services based on lack of, or limited personal financial resources. Costs to you for travel and loss of work time will be discussed and kept at a minimum. No physical barriers will preclude treatment.
3. Services will be provided with a minimum of waiting time. Agency service hours will be reasonably convenient to all consumers requesting services.
4. You have the right to have your disability accommodated as required by the Americans with Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act (775ILCS-5)

CONFIDENTIALITY
1. The right of clients to confidentiality shall be governed by the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) and the Health Insurance Portability and Accountability Act of 1996.
2. All information concerning you is held confidential and released only though procedures consistent with the law and professional ethics. (The Courts without your permission can subpoena your records).
3. You have a right to review and approve any information being requested by another giving services to you. You must sign a release for any such information to be sent.
4. Special circumstances regarding client confidentiality: participation in public performances for the use of identifiable photographs or videotapes to be used for public relations purposes on behalf of Family Service Association of Greater Elgin Area is prohibited without your informed consent. Participation in such activities is voluntary. Refusal to participate in such activities will not curtail or limit in any way your access to services of the agency.

TREATMENT
1. You have the right to an individual plan for services and will expected to participate in planning.
2. You have the right to know the name and professional credential of anyone working with you.

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3. You may request to participate in any staff meeting regarding yourself.
4. You may review your clinical records upon written request.
5. You will be assigned a primary clinician who will assist you in obtaining services as agreed upon in your individual plan for services. In most cases, this will also be your therapist.
6. You have the right of informed consent with regard to all aspects of services provided by our agency.
7. You will be advised of the positive effects and possible complications of any treatment offered at the agency.
8. You have the right to refuse to participate in, or be interviewed for research purposes.
9. You have the right to terminate services at any time.
10. You have the right to refuse treatment.
11. If you are a minor who is at least 12 years of age, requesting services without parental consent, you have the right to receive five (5) forty-five (45) minute sessions prior to obtaining parental consent.

**GRIEVANCE PROCEDURE**
1. If a client/guardian feels that services have not been provided fairly or reasonably they should attempt to resolve this with their therapist.
2. The therapist will inform his/her supervisor of any client grievance which he/she has been unable to resolve.
3. If a client/guardian is unable to resolve this issue with their therapist or feels uncomfortable communicating direction with their primary clinician the client/guardian may present their concerns, in writing to the primary clinician’s immediate supervisor.
4. If a client/guardian feels their grievance has not been properly attended to by the therapist’s immediate supervisor, the client/guardian has the right to ask that their grievance be pursued up the administrative structure of the agency up to and including the Chairperson of the Governing Board of Directors, as needed.
5. The supervisor ill respond to any phone calls or messages that the client/guardian may leave indicating a request to file a grievance.
6. The supervisor will attempt to resolve the grievance within five working days. If the supervisor is unable to do so, he/she will forward the matter to the Director of Clinical Services.
7. The Director of Clinical Services will attempt to resolve this grievance within five working days. If the Director of Clinical Services is unable to do so, he/she will forward the matter to the Executive Director.
8. The Executive Director will attempt to resolve the grievance within five working days. If the Executive Director is unable to do so, he/she will forward the matter to the Chairperson of the Governing Board of Directors. Prior to forwarding the grievance to the Chairperson of the Governing Board of Directors, due care will be taken to assure that the grievance has no client identifying information. In the case of a Board member recognizing a client, they will be expected to abide by the Illinois Department of Mental Health and Developmental Disabilities Confidentiality Act and Health Insurance Portability and Accountability Act of 1996.
9. The Chairperson of the Governing Board of Directors will convene the Executive Committee of the Governing Board to hear the grievance and will attempt to resolve the grievance within five working days. They will notify the Executive Director of the resolution to the complaint.
10. The client/guardian will be informed of the resolution of any grievance in writing and of the outside appeals process as needed. Every effort will be made to resolve client grievances within 30 days of the initial grievance.
11. If a client/guardian believe their grievance has not been properly attended to within this agency, they have the right to contact the Illinois Department of Human Service, Division of Mental Health.

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12. Your filing and pursuit of grievance will in no way, by itself, curtail or limit in any way your access to the services of this agency.

MUTUAL RESPONSIBILITIES OF AGENCY AND CONSUMER
1. Deciding on the plan for services.
2. Determining the frequency and duration of consumer involvement.
3. Involving family members or significant others in services.

AGENCY RESPONSIBILITY
1. Assigning a clinician.
3. Making referrals to other service agencies.
4. Billing for services either directly or through insurance, or other third party payees.
5. Communicating with courts or responsible officials thereof, as mandated by statute, rule, or court decision.
6. Use all means at the agency’s disposal to provide an atmosphere for the client that is free of the imminent or potential threat of physical, emotional, sexual, or any other type of abuse or neglect.
7. Refusing services if request is not appropriate.

EACH CLIENT SHALL BE GIVEN A COPY OF THE STATEMENT OF RIGHTS FOR HIS/HER PERSONAL USE.

In the event that a client of this agency brings a formal grievance against this agency, and the grievance is not resolved within the agency, the client may pursue the grievance through one of the following offices:

1. Guardianship and Advocacy Commission (GAC)
   421 E. Capitol Street
   Springfield, IL 60701
   217.785.0645
   9551 Harrison Ave., FA101
   Des Plaines, IL 60016
   847.294.4264
   527 S. Wells, Suite 300
   Chicago, IL 60607
   312.793.5900

2. Equip for Equality
   11 E. Adams St., Suite 1200
   Chicago, IL 60603
   800.537.2631

3. Department of Human Services/Office of Mental Health
   401 S. Spring Street
   Springfield, IL 62765
   217.782.6154
   160 N. LaSalle
   Chicago, IL 60601
   213.814.3785

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Family Service Association of Greater Elgin Area

CONSENTS AND SIGNATURES

I. Client Consent to Treatment:

My/Our signature(s) affirm that the aforementioned therapist has disclosed to me/us in clear, non-technical language the nature of the assessment and therapy process. This disclosure included the risks and benefits of treatment, the alternatives available to me/us and the risks of no treatment. This disclosure was understood by me/us and enabled me/us to make an informed consent to this treatment process. I/we understand that I/we may revoke this consent at any time. If consent is revoked, a new treatment plan may be developed, or if consent by both client(s) and therapist cannot be reached, this agency will make a reasonable effort to provide a list of more appropriate/acceptable treatment options through other mental health services.

Client Name: ___________________________ (Please Print)

If client is age 12 or over:

Client Signature ___________________________ Date: ___/___/___

If Client is under 18 years of age, Parent or Guardian must sign

Parent/Guardian ___________________________ Date: ___/___/___

Witness Signature _________________________ Date: ___/___/___

II. Statement of Rights, Behavior Management Policy, Fee Agreement and Emergency Policy

___ I acknowledge that I have been given a personal copy of the Statement of Rights. My rights have been explained to me clearly and I understand what they are.

___ I acknowledge that I have been given a copy of the Behavior Management policy and it has been explained to me.

___ I have read and received a copy of the Client Fee Agreement policy regarding my financial obligations for services that are provided to me and my family.

___ I have received a personal copy of the Client Emergency Plan.

I agree to pay the set fee of $______ per hour for therapy services.
I agree to pay the set fee of $______ per hour for case management services.
I agree to pay the set fee of $______ per hour for psychiatric services.

All ages must sign for client rights:

Client Signature ___________________________ Date: ___/___/___

If Client is under 18 years of age, Parent or Guardian must sign

Parent/Guardian: ___________________________ Date: ___/___/___

Staff Signature: ___________________________ Date: ___/___/___

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Family Service Association of Greater Elgin Area
Acknowledgement of Notice of Privacy Practices

I, _______________________________ acknowledge that I/we have received a copy of the Notice of Privacy Practices and Rights for Family Service Association of Greater Elgin Area. I understand that I may contact the designated Privacy Officer at Family Service Association if I feel that my privacy has been violated.

Client Signature (age 12 and older) ___________________________ Date __________

Parent/Guardian Signature ___________________________ Date __________
EMERGENCY/CRISIS INSTRUCTIONS

My assigned clinician is: ______________________________

The agency is committed to offering you emergency services when necessary.

An emergency is defined as:

- A time when you feel a danger exists to yourself or someone else, but 911 is not appropriate to contact.
- A time when you are unable to care for yourself due to mental illness.
- You feel, as a parent, that your child is at risk of hurting themselves or someone else, but 911 is not appropriate to contact.

In an emergency, you may need to call your clinician (or another available agency clinician) to discuss what actions to take, or to get assistance stabilizing the situation.

Emergency Contact Instructions:

- Call 847-695-3680
- Tell the person that answers the phone that you have an emergency and need to contact your counselor. Give the counselor’s name.
- If your counselor is available, you will be put in contact with them. If your counselor is not available, a supervisor or another on-call counselor will be connected with you.

Non-Emergency Contact Instructions:

Call the agency during normal business hours, which are Monday through Thursday 9am-8pm, Friday 9am-5pm, Saturday by appointment, closed on Sundays. If your counselor is available, you will be put in contact with them. If your counselor is not available, you will be offered the opportunity to leave a message on their confidential voicemail.

Please note: Calls related to scheduling, canceling, changing, or confirming an appointment are NOT considered emergencies by the agency. For purposes of confidentiality, when someone from our agency contacts you via telephone, the agency phone number may show up on your phone’s caller identification as “restricted”, “blocked”, “private” or “unavailable”.

If you have any questions about these instructions, please discuss them with your counselor.

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INCOME VERIFICATION FORM

Please attach copies of income verification to this form and submit to Intake Coordinator after the first session.

Client Name: ____________________________________________

Client Id #: ____________________________________________

Household Size: _________________________________________

Household Monthly Income: ________________________________

Client Income: __________________________________________

Date: _________________________________________________

Therapist Signature: _____________________________________

Client/Parent/Guardian: __________________________________

Statement from Consumer regarding Qualifying Exception:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Consent to Release Confidential Information

Insurance Company/Medicaid

Primary Carrier ___________ Secondary Carrier ___________

Insurance Company: ________________________________
Phone Number: ________________________________
Address: _______________________________________

Employer Name: ________________________________
Phone Number: ________________________________
Address: _______________________________________

Policy Number: ________________________________
Social Security Number: _________________________
I.D. Number: ________________________________

PLEASE GIVE YOUR INSURANCE IDENTIFICATION CARD TO YOUR THERAPIST TO COPY

1. I give Family Service Association of Greater Elgin Area permission to bill my insurance company for services received from the agency.

2. I give Family Service Association of Greater Elgin Area permission to release my name, address, date of birth, mental health diagnosis, treatment plan, date of service and type of service received from the agency only as required by my insurance company in order to process the claim.

3. I have been told that I have the right to review the information to be released. I understand that signing this form is not a required condition of receiving services from the agency and that I can withdraw this permission at any time.

4. I understand that the agency will submit a mental health diagnosis (from the Diagnostic and Statistical Manual, 4th Edition revised) for the person identified as the patient on the insurance claim form.

5. This authorization to release information expires: ____________________

_________________________ ___________________________
(Client signature) (Date)

_________________________ ___________________________
(Witness signature) (Date)

If the client is under 12, or has a court appointed guardian, this release must be signed by the client's parent or guardian.

_________________________ ___________________________
(Parent or guardian signature) (Date)
Family Service Association of Greater Elgin Area  
1140 N. McLean Blvd, Suite I, Elgin, IL 60123  (847) 695-3680  

Consent for Release of Confidential Information

I hereby authorize Family Service Association of Greater Elgin Area staff to release/exchange written, oral, or electronically transmitted protected health related information about:

Name: ___________________________________________ DOB: ___ / ___ / ___

To: Name/Organization:

Information to be released/exchanged: (check all that apply)
☐ Comprehensive Assessment  ☐ Treatment Plan  ☐ Progress Notes  ☐ Substance Abuse
☐ Psychiatric Evaluation/Notes  ☐ Discharge Summary  ☐ Social History  ☐ Medical Information
☐ Other Please Specify:

For the purpose of:
☐ Exchange of information  ☐ Continuity of Care  ☐ Case Management/Consultation
☐ Other Please Specify:

This authorization to release information expires: ___ / ___ / ___ (not to exceed one year)

- I understand that the above named person/organization authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

- I understand that I may revoke this consent at any time; however, the revocation must be in writing. I understand that no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

- Refusal to consent to release of information will result in the following consequences: INFORMATION WILL NOT BE RELEASED which may result in inability to provide effective service coordination.

- It is my full understanding that the records and communications to be disclosed may contain evaluation and/or treatment information for mental health, developmental disabilities and/or alcohol or substance use/abuse and that my signature indicates my informed consent.

- I understand that I can inspect and/or copy information before it is released by making my request in writing. In addition, I understand that I can request a copy of this release of information.

_________________________________________  __________________________
Client Signature (age 12 and older)  Date

_________________________________________  __________________________
Parent/Guardian Signature  Date

_________________________________________  __________________________
Witness Signature  Date

NOTICE TO RECEIVING PERSON/ORGANIZATION: If you are a healthcare provider, you are subject to the HIPAA Privacy Rule related to re-disclosure of information. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, that no such records, nor information from such records may be further disclosed without the specific authorization from the individual for such re-disclosure.  
(Revised 10/12)
Family Service Association of Greater Elgin Area
1140 N. McLean Blvd, Suite I, Elgin, IL 60123    (847) 695-3680

Consent for Release of Confidential Information

I hereby authorize Family Service Association of Greater Elgin Area staff to release/exchange written, oral, or electronically transmitted protected health related information about:

Name: ___________________________________________ DOB: / / 

To: Name/Organization: _________________________________________________________________

Information to be released/exchanged: (check all that apply)
☐ Comprehensive Assessment  ☐ Treatment Plan  ☐ Progress Notes  ☐ Substance Abuse
☐ Psychiatric Evaluation/Notes  ☐ Discharge Summary  ☐ Social History  ☐ Medical Information
☐ Other  Please Specify: ________________________________________________________________

For the purpose of:
☐ Exchange of information  ☐ Continuity of Care  ☐ Case Management/Consultation
☐ Other  Please Specify: ________________________________________________________________

This authorization to release information expires: / / (not to exceed one year)

• I understand that the above named person/organization authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

• I understand that I may revoke this consent at any time; however, the revocation must be in writing. I understand that no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

• Refusal to consent to release of information will result in the following consequences: INFORMATION WILL NOT BE RELEASED which may result in inability to provide effective service coordination.

• It is my full understanding that the records and communications to be disclosed may contain evaluation and/or treatment information for mental health, developmental disabilities and/or alcohol or substance use/abuse and that my signature indicates my informed consent.

• I understand that I can inspect and/or copy information before it is released by making my request in writing. In addition, I understand that I can request a copy of this release of information.

_________________________________________ __________________________
Client Signature (age 12 and older)        Date

_________________________________________ __________________________
Parent/Guardian Signature                 Date

_________________________________________ __________________________
Witness Signature                        Date

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