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: __/__/__
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 __________
Family Service Association of Greater Elgin Area  
1140 N. McLean Blvd, Elgin, IL 60123  847-695-3680

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.

Rev. 06/2013
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:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Family Service Association of Greater Elgin Area
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: ________________
ID. 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)