Family Service Association OF GREATER ELGIN

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.

Family Service Association OF GREATER ELGIN

Consent To Treatment

Assigned Clinician: _____

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.

☐ ***I attest that I am legally able to consent for the services provided herein.***

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 Signature _____ Date: _____

Witness Signature _____ Date: _____

Family Service Association OF GREATER ELGIN

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 Signature: _____

Statement from consumer regarding qualifying exception:

Family Service Association OF GREATER ELGIN

Policy Acknowledgement Form

☐ 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 acknowledge that 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 acknowledge that I have received a personal copy of the Client Emergency Plan.

☐ I acknowledge that I have received a copy the HIPAA/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 rights are being violated.

I agree to pay the following fees per hour for the following services:

$**_____ Therapy **$_____ Case Management **$**_____ 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 Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Family Service Association OF GREATER ELGIN

Consent To Release Confidential Information To 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 I have the right to review 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 current diagnostic and Statistical Manual from the APA) for the person identified as the patient on the insurance claim form.

This authorization to release information expires in 1 year: _____

_____ _____

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/Guardian Signature Date

Family Service Association OF GREATER ELGIN

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/ORGANZIATION: 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.

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