

WELCOME TO IHR

We at IHR would like to take a few minutes to introduce you to our services. In a few minutes, you will be meeting with your therapist. Today will be an assessment session; focused upon gathering basic information about you (or your family member) and your presenting problem(s). To get a thorough assessment, you and your therapist may need to focus upon gathering this information for several sessions. In doing so, there may be some forms for you to go over and fill out with your therapist. After the assessment process is complete and you and your therapist have an understanding of what to work on, a treatment plan will be written to formalize treatment goals. This helps to ensure sessions stay focused upon the necessary issues and provides a means of determining if progress is being made or not.

If at any time you are uncomfortable with your therapist or feel there is a “lack of connection,” we strongly encourage you to bring this to your therapist’s attention. This is a problem which needs to be addressed and can often be corrected if we are made aware of the problem.

We would also like to take this opportunity to make you aware of our 24-hour crisis availability. If you find yourself in a crisis situation, you can reach us at **844-6109** at anytime. If our office is closed at the time you call, you will receive a voice prompt to press #1 to access our service called PATH. They will assist you in any way they can, including paging our crisis workers who are trained to provide crisis counseling. If you need more information regarding this service, please ask your therapist.

We look forward to meeting with you and assisting you or your family member in working toward greater, positive mental health.

IHR Staff

Who referred you to IHR?

- State aided facility
- Hospital/physician
- Alcoholics Anonymous
- Corrections or court
- Employer
- Family
- Self
- School
- Law Enforcement Agency
- Other _____

If self, family, or friend referred you to IHR, how did you or they hear of IHR?

- previously seen at IHR
- Radio
- Newspaper
- Telephone directory
- Friend
- Family
- Another agency
- IHR public speaker
- Other _____

MEDICAL INFORMATION:

Who is your physician? _____

Date of last physical examination _____

List current medications, if any _____

Do you have a physical disability (If so, explain)? _____

In case of emergency, please notify:

Name _____ Relationship _____

Phone numbers: Home _____ Work _____

Address _____

City _____ State _____ Zip _____

SUBSTANCE USE INFORMATION

Please check all of the substances that you have used or are currently using:

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Marijuana/Hashish |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Hallucinogens |
| <input type="checkbox"/> Prescription medicines | <input type="checkbox"/> Inhalants |
| <input type="checkbox"/> Other opiates and synthetics | <input type="checkbox"/> Over-the-counter medications |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> PCP |
| <input type="checkbox"/> Non-barbiturate sedatives | <input type="checkbox"/> Crack |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Club Drugs |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Other _____ |

Previous substance abuse treatment:

- Alcoholics Anonymous/Alanon only
- Outpatient program
- Intensive outpatient program
- Inpatient program
- Other _____
- None of the above

Time since last treatment:

- | | |
|--|--|
| <input type="checkbox"/> 0 - 1 week | <input type="checkbox"/> 4 - 6 months |
| <input type="checkbox"/> 1 - 2 weeks | <input type="checkbox"/> 6 mo. - 1 yr. |
| <input type="checkbox"/> 2 wks - 1 mo. | <input type="checkbox"/> 1 - 2 years |
| <input type="checkbox"/> 1 - 2 months | <input type="checkbox"/> 2 - 5 years |
| <input type="checkbox"/> 2 - 4 months | <input type="checkbox"/> Over 5 years |

Are you currently in any legal difficulty? Yes No

If yes, please explain _____

FINANCIAL INFORMATION

Family Income (please estimate if you do not know exactly) \$ _____/yr

Individual Income per year \$ _____

Source of Family Income (please check all that apply):

- Wages/Salary
- Public Aid/Food Stamps
- Retirement/Pension
- Disability
- SSI
- SSDI
- XIX
- Medicare
- Medicaid
- VA Disability Income
- Other _____
- None

Total Family size (including yourself) _____ Total number of dependents _____

Who lives in your household?

<u>Name</u>	<u>Age</u>	<u>Relationship</u>

Do you have insurance? Yes _____ No _____ (If yes, please complete page 4.)

Do you receive Public Aid? Yes _____ No _____

If yes, please present your public aid card to the receptionist so a copy can be made for your file.

Public Aid Case # _____ Public Aid Recipient # _____

What is your employment status?

- Full-time
- Part-time
- Unemployed
- Retired
- Homemaker
- Full-time student
- Sheltered employment
- Other _____

How long have you been employed?

- 0 - 3 months
- 4 - 6 months
- 7 - 12 months
- 13 months - 2 years
- Over 2 years

If employed, who is your current employer? _____

Are you a veteran? Yes _____ No _____

INSURANCE INFORMATION

If you are eligible to have a portion of your services covered by the Illinois Department of Human Services, you must provide IHR with your social security number. If you choose not to provide your social security number, you will be required to pay 100% of your counseling fees. Disclosure of your social security number is required pursuant to federal regulation 42 U.S.C. Section 405 (c) (2). Your social security number will be used to contract eligibility for service, accumulate benefits used across payers, and detection and possible prosecution of fraud.

Primary Insurance Carrier _____

Policy Number _____

Address _____ Phone _____

Policy Holder Name _____ SS# _____ Birthdate _____

Employer _____

Secondary Insurance Carrier _____

Policy Number _____

Address _____ Phone _____

Policy Holder Name _____ SS# _____ Birthdate _____

AUTHORIZATION TO RELEASE INFORMATION:

I give my permission to the Institute for Human Resources to release any information necessary (including diagnosis) to:

(Name of Insurance Company)

for the purpose of determining my eligibility and/or coverage for pending services. If services are covered, I authorize release of any information necessary to process my claim.

Client Name _____

Signature of Client _____ Date _____

(or parent if client is a minor)

ASSIGNMENT OF INSURANCE BENEFITS:

I agree to assign any and all insurance benefits connected to treatment rendered by the Institute for Human Resources to said center. I understand that a photocopy of this assignment will be forwarded with all claim forms submitted.

Signature _____ Date _____

(Policy Holder or Authorized Signer)

Institute for Human Resources
Family Members or Significant Others Rights

Though your family member or significant other is the primary client receiving counseling, you have the same rights as he/she does since you are participating in his/her services. Please remember that you do not have the right to access of your family member or significant other's chart nor confidential information about him/her without their expressed written consent.

The following are a list of your Rights:

1. Access to services will not be denied on the basis of race, religion, ethnicity, disability, sexual orientation or HIV status.
2. Services will be provided in the least restrictive environment available.
3. Confidentiality of HIV/AIDS status and testing is assured according to all state regulations and federal guidelines.
4. The right to non discriminatory access to services as specified in the Americans With Disabilities Act of 1990.
5. The right to give or withhold informed consent regarding services and regarding confidential information about the client.
6. A description of the steps to appear when a person disagrees with IHR's decisions or policies.
7. Confidentiality of client records as specified in all state regulations and federal guidelines.
8. The right to refuse services or any specific service procedure and a right to be informed of the consequences resulting from such refusal.

I have read and understand the above. My signature authorizes IHR to provide diagnostic and counseling services to me or to my minor child/ward. My signature attests that I have received a statement of these Rights.

Family Member/Significant Other's Signature: _____

Date: _____ Witness: _____

**Consent for the Release of Information
To Coordinate Care with Primary Physicians**

See reverse for a list of physicians

A. PATIENT INFORMATION

Patient Name _____
(Last) (First) (Initial)

Patient Address _____
(Street) (City) (State) (Zip)

Patient Date of Birth _____ Patient Phone Number _____

B. PROVIDER INFORMATION

IHR
Provider Name
P.O. Box 768
(Address)
310 E. Torrance Ave.
(Street)
Pontiac IL 61764
(City) (State) (Zip)

C. PRIMARY PHYSICIAN INFORMATION

Primary Physician Name

(Address)

(Street)

(City) (State) (Zip)

Telephone Number 815-844-6109 Telephone Number _____

The undersigned authorizes the provider and primary physician to **release/obtain** the following medical records and information concerning patient. The purpose of such release is to allow for coordination of care, which enhances quality, and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

Nature of the information diagnosis prognosis intake summary
 discharge summary treatment plan { } progress note social history
{ } psychological evaluation medications testing results recommendations
 psychiatric consultation { } legal history medical history drug/alcohol
 attendance record { } other _____ history

Purpose for Disclosure: Coordinating Services

MY SIGNATURE BELOW WILL INDICATE THAT I HAVE READ AND UNDERSTAND THE INFORMATION WHICH FOLLOWS. I UNDERSTAND:

1. That information will only be disclosed when this document is completed and signed by me and witnessed, except as provided by Federal and State Regulations on confidentiality.
2. That this consent may be modified or revoked by me at anytime upon written request to the party releasing the information, except to the extent that action has already been taken in reliance on this authorization.
3. That this consent will expire on _____ (date).
4. That I have the right to inspect or copy information to be released by IHR under the terms of this consent.
5. That failure to consent to such release of information may have an impact on the quality of services to be provided, but will not be grounds for termination of services by IHR.
6. The agency/person receiving information under the terms of this consent are not allowed to further release or disclose said information to any other person or agency without my specific written consent to do so.

I am willing that a reproduction of this consent be accepted with the same authority as the original.

SIGNATURE OF CLIENT: * _____
SIGNATURE OF PARENT/GUARDIAN (if client under 12) _____
ADDRESS _____
DATE _____ WITNESS _____

Dr. Brewer and Dr. Austmin
122 E. Wasbash
Forrest, IL 61741
657-8707

Dr. Burnett
2500 W. Reynolds
Pontiac, IL 61764
844-6551

Dr. Fernandez
106 S. First
Fairbury, IL 61739
635-3177

Dr. Heins
520 W. Madison
Pontiac, IL 61764
844-6106

Dr. Hough
222 E. Water
Pontiac, IL 61764
844-6123

Dr. Jordan
520 W. Madison
Pontiac, IL 61764
844-6106

Dr. Lemmert
2500 W. Reynolds
Pontiac, IL 61764
842-3633

Dr. Manabat
1504-C W. Reynolds
Pontiac, IL 61764
842-2893

Dr. Norris
2500 W. Reynolds
Pontiac, IL 61764
842-3633

Dr. Patel
222 E. Water
Pontiac, IL 61764
844-6123

Dr. Proehl
2500 W. Reynolds
Pontiac, IL 61764
842-3633

Dr. Purnell
401 E. Water
Pontiac, IL 61764
842-1166

Dr. Rinker
1515 W. Reynolds
Pontiac, IL 61764
842-3381

Dr. Schweizer
106 S. First
Fairbury, IL 61739
692-2308

Dr. Siddiqui
2500 W. Reynolds
Pontiac, IL 61764
844-5115

Dr. Smith
115 E. Walnut
Fairbury, IL 61739
692-2305

Dr. Stalter
103 W. South
Flanagan, IL 61740
796-4591

Dr. Swink
105 John
Dwight, IL 60420
584-3343

Dr. Yerrabolu
2500 W. Reynolds
Pontiac, IL 61764
844-5115

*INSTITUTE FOR HUMAN RESOURCES
310 E. TORRANCE AVE.
PONTIAC, IL 61764
(815) 844-6109*

**NOTICE OF PRIVACY PRACTICES
AND CLIENT RIGHTS**

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.

Effective Date: April 14, 2003

We respect patient/client confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by this Agency.

Privacy Contact. If you have any questions about this policy or your rights, contact Joe Ronaldson, Executive Director or Steven Barnard, Privacy Officer at (815) 844-6109.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your right to confidentiality will be governed by the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS110) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond our Agency. This includes:

Treatment/Service Information. With your written consent, we may use or disclose treatment/service information about you to provide, coordinate, or manage your care or any related treatment/services, including sharing information with others outside our Agency that we are consulting with or referring you to.

Payment. With your written consent, information will be used to obtain payment for the treatment/services provided. This will include contacting your health insurance company for prior approval of planned treatment/services or for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointment/Care. We will be contacting you to remind you of future appointments or information about treatment/service alternatives or other health-related benefits and treatment/services that may be of interest to you. **We will leave appointment information on your answering machine unless you tell us not to.**

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners. We are required to disclose information about the circumstances of your death to a coroner who is investigating it.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. We are also required to share information, if requested with the U.S. Department of Health and Human Services to determine our compliance with federal laws related to health care and to Illinois state agencies that fund our treatment/services.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel, we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

CLIENT RIGHTS STATEMENT

As a client of the Institute for Human Resources, you have the following rights under Illinois and federal law. Your rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (405 ILCS 5). You have the right:

1. To not be denied treatment/services on the basis of age, sex, race, religious beliefs, ethnic origin, marital status, physical or mental disability, sexual orientation, HIV status, or criminal record.
2. To treatment/services provided in the least restrictive environment available for your needs pursuant to an individualized treatment/service plan. You will have nondiscriminatory access to treatment/services in accordance with the Americans with Disabilities Act of 1990 (42 USC 12101).
3. Confidentiality of your status and records, including HIV status and testing as provided for under Illinois law. We are bound both by law and our own ethical code to respect your confidentiality. Clients with substance abuse issues are further protected by Federal Confidentiality Regulations (see 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, 1987). Moreover, all client records are governed by the AIDS Confidentiality Act (410 ILCS 305) and AIDS Confidentiality and Testing Code (77 Ill. Admin. Code 697). As per Section 7 of the Federal Privacy Act and the Federal Regulations on the Confidentiality of Alcohol and Drug Abuse Patient Records, disclosure of your social security number is required pursuant to federal regulations 42 U.S.C. Section 405 (c) (2). Your social security number may be used for identification, determination of Medicaid and contract eligibility for treatment/service, accumulation of benefits used across payers, and detection and possible prosecution of fraud. No information about a client will be discussed with or released to another person without a specifically signed consent from you, the client, except under very special circumstances.
4. Our Agency has the right to limit treatment/services based on the funding we receive. This may require us to prioritize treatment/services based on the severity of your treatment/service needs. Treatment/services not covered by governmental grants are charged based on the cost of providing those treatment/services.
5. No client shall be presumed legally disabled unless declared so by a court.
6. You have the right to give an informed consent to treatment/services. You also have a right to refuse treatment/services and be told the consequences of such refusal. This could include the Agency being unable to provide treatment/services to you.
7. If you believe your rights have been violated, you have the right to contact any of the following groups: Clients have the right to follow the agency's grievance procedure and to contact Equip for Equality, 422 E. Monroe St., Suite 302, Springfield, IL 62705 (800/758-0464), Guardianship and Advocacy, 421 East Capitol, Suite 205, Springfield, IL 62701 (217/785-1540), Office of Inspector General (800/368-1463), Illinois Department of Human Services (800/843-6154), and Department of Children and Family Services (844-1551). Staff shall offer assistance in contacting these groups if client so desires.
8. If you have a complaint about the treatment/services provided, you may file a grievance by doing the following: Individuals or guardians shall be permitted to present grievances and to appeal adverse decisions of the provider up to and including the executive director. A record of such grievances, appeals, and responses thereto will be maintained by the provider. The executive director's decision in the grievance shall constitute a final administrative decision and shall be subject to review in accordance with the administrative Review Law. (735 ILCS 5/Art.III).
9. Every client shall be free from abuse, neglect, financial or other exploitation, and humiliation.
10. Individuals shall not be denied, suspended, or terminated from treatment/services or have treatment/services reduced for exercising any of their rights.

Copy of Record. You are entitled to inspect the client record our Agency has generated about you. We may charge you a reasonable fee for copying - \$1.00/page for the first 5 pages and .50/page for each page thereafter.

Release of Records. You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this, contact the **Privacy Officer** and ask for the Request to Amend Health Information form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response; your statement and our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment/services, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints, you may contact our Privacy Officer in writing at our office for further information. You also may complain to the Secretary of U.S. Department of Health and Human Services if you believe our Agency has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. The Agency reserves the right to change its Privacy Policy based on the needs of the Agency and changes in state and federal law.

CLIENT AGREEMENTS AND AUTHORIZATIONS

***** Client/Guardian please initial each statement below (Guardian must initial if client is under 18).**

CONSENT FOR TREATMENT/SERVICES. I hereby consent to the treatment/services provided by the Institute for Human Resources and its employees or designees. I authorize the treatment/services deemed necessary to address my needs. (_____) **PLACE INITIALS HERE**

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 the Agency. I authorize the Institute for Human Resources to release any information required in the process of applications for financial coverage for the treatment/services rendered. This authorization provides that the Institute for Human Resources may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (_____) **PLACE INITIALS HERE**

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/ COLLECTION FEE. I authorize payment to be made directly to the Institute for Human Resources for insurance benefits payable to me. I understand that I am financially responsible to the Agency for any covered or non-covered treatment/services, as defined by the insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees. (_____) **PLACE INITIALS HERE**

PRIVACY POLICY. I acknowledge having been offered the Agency's "Notice of Privacy Policies and Client Rights" statement. I understand that as a client of IHR my rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5], the Confidentiality Act and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. My right including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to record, is explained in the Policy. My right to make a complaint and file a grievance under Illinois laws has also been explained. I understand that I may revoke in writing my consent for release of my health information, except to the extent the Agency has already made disclosures with my prior consent. (_____) **PLACE INITIALS HERE**

***** Guardian must sign if the client is under the age of 18**

Client Name Printed

Client or Authorized Person Signature Relationship Date

Witness Signature Date
Client unable to sign. Verbal consent given. Reason _____ -

As staff member of IHR, I affirm that I have explained these rights to the client/guardian in a language or a method of communication he/she understands and believe these rights to have been understood.

Staff Signature

Date

F:HIPAA\client rights rev 11-06

**Institute for Human Resources
310 E Torrance Ave., Pontiac, IL 61764
(815) 844-6109**

Client Rights

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1. You have the right to be provided with mental health or substance abuse services in the least restrictive setting.
2. You have the right to be free from abuse, neglect, financial and other exploitation, and humiliation.
3. Justification for restriction of your rights as cited in Chapter 2 of the Mental Health and Developmental Disabilities Confidentiality Code [405 ILCS 5], the Confidentiality Act, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 shall be documented in your clinical record. You have the right to be notified of that restriction(s) of your rights. Your parent or guardian and any agency you designate (as listed in item No. 4 below) shall also be notified of the restriction.
4. You have the right to contact the Guardianship and Advocacy Commission and Equip for Equality, Inc. You have the right to be offered staff assistance in contacting these groups and staff will provide you with the address and telephone number of either of the above groups you wish to contact.
5. You have the right to contact the public payer.
6. You or your guardian have the right to present grievances up to and including the Executive Director, Joe Ronaldson. A record of such grievances and the response to those grievances shall be maintained. The Executive Director's decision on the grievance shall constitute a final administrative decision (except when such decisions are reviewable by the provider's governing board, in which case the governing board's decision is final).
7. You are entitled to have your rights explained to you using a language or method of communication you understand, with such explanation placed in your record.
8. You have the right not to be denied, suspended or terminated from services or have services reduced for exercising any rights.

Client or Authorized Person Signature

Date

As staff member of Institute for Human Resources, I affirm that I have explained these rights to the client in a language or a method of communication he/she understands and believe these rights to have been understood.

Staff Signature

Date