



CLIENT AGREEMENTS AND AUTHORIZATIONS

INFORMED CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Union County Counseling Services, Inc. and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. I understand that treatment for a mental illness can assist in my recover of function but treatment will not provide a cure. **I know all of the risks and costs involved in the treatment, including the nature of treatment, possible alternative treatments, and the potential risks and benefits of the treatment** (____)

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 Agency to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Agency may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (____)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/

COLLECTION FEE. I authorize payment to be made directly to the Agency for insurance benefits payable to me. I understand that I am financially responsible to the Agency for any covered or non-covered services, as defined by my 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 attorneys fees. (____)

PRIVACY POLICY. I acknowledge having received the Agency's, "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Agency has already made disclosures with my prior consent. (____)

PROGRAM RULES. I acknowledge that I have received a copy of the program rules for **Outpatient services at UCCS.** (____)

Client or Authorized Person Signature

Relationship

Date

Print Name

Name of Minor (if applicable)

Witness Signature

I have explained client rights and **Program Rules** and believe that s/he understood them.

Staff Signature

Date



RIGHTS OF CLIENTS

A client has a right to adequate notice of the uses and disclosures of Protected Health Information (PHI) that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to PHI.

The Notice of Privacy Practices summarizes all the rights of the client related to his identifiable health information.

The Client has the Following Rights:

1. **Right to Request Restrictions of Uses and Disclosures of PHI.** An entity must permit a patient to request that the covered entity restrict:
 - (A) Uses or disclosures of PHI to carry out TPO; and
 - (B) Listing client in its directory of individuals in the facility. (The client has a right to object to this information being shared with clergy.)
 - (C) Sharing information with client's family member, relative or close personal friend.

The covered entity is not required to agree to the above restriction, but if it does, it may not use PHI in violation of such restriction except for emergency treatment.

2. **To Request to Receive Communications of PHI by Alternative Means or at Alternative Locations.** The right to communication of PHI by alternative means or location unless the request is unreasonable. Alternative contact information may be required before the request can be honored. Once the request is accepted, every effort is made to communicate in the stated manner. Alternative communication requests remain in effect until the Agency receives a written request to change the manner of communication.
3. **Right to Copy of Record.** This right currently exists for all clients under various Illinois statutes, including those seeing general health care providers, those receiving specialized care for mental health, substance abuse, or AIDS treatment. An individual's access may be denied if the PHI was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. (This denial is very problematic under Illinois law).
4. **Denial of Access.** Although there are various circumstances where HIPAA allows the provider to deny access, these provisions are preempted by Illinois law, which allows the client access to his record in almost all circumstances.
5. **Timely Access.** Under HIPAA, copies of records are to be provided within 30 days.
6. **Right to Amend PHI.** The client has a right to have the Provider amend PHI as long as it is maintained in the designated record set. The Provider can deny making the amendment based on:
 - (a) The record was not created by the Provider; or
 - (b) The information is not part of the designated record set; or
 - (c) The information is accurate and complete.

The Provider is to act within 60 days. See Request for Amendment of Clinical Record Form. A Provider can deny an amendment. The client can disagree with the denial, and then submit a statement, and the Provider can submit a rebuttal statement. This can all become part of the record.

Generally, if the client is disputing something in the record and it is questionable, then the Provider should include in the record the client's comments and make that part of the record. If the Provider accepts amending the record, then the Provider should also notify others identified by the client as having received the PHI and needing the amendment.

7. Accounting for Disclosures of PHI. The client has a right to receive an accounting of the disclosures made of his PHI for a period of six years prior to the date the accounting is requested. This does not include giving an accounting when the disclosures were for:
 - (a) Used to carry out treatment, payment and health care operations. (TPO)
 - (b) Released due to a patient's authorization.
 - (c) To persons involved in the individual's care.
 - (d) That occurred prior to the compliance date for the covered entity.
 - (e) Disclosures that are part of a limited data set.
 - (f) Disclosures that are merely incidental to another permissible use or disclosure.

The six years begins to run forward starting with the effective date of April 14, 2003 or the first date of treatment by the patient after April 14, 2003.

The accounting must include the date of the disclosure and whom it was released to and a brief description of the PHI that was disclosed.

UNION COUNTY COUNSELING SERVICES, INC
STATEMENT OF RIGHTS

This agency is committed to insure that you receive professional and humanistic services directed toward your needs in a manner that protects your dignity and feelings of self-worth. As a client of our Agency you have the following rights:

CIVIL RIGHTS

1. You have the right to be treated with dignity and respect and,
2. You retain all rights, benefits, and privileges guaranteed by law.

DISCRIMINATION

Services will be provided to you and/or your family members without discrimination. Race, color, creed, religion, national origin, sex, sexual orientation, HIV/AIDS status, age, marital status, disability, financial status or status as a disabled veteran or Vietnam era veteran will not affect our services to you. You have a right to disabilities accommodations as required by the American With Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS 5].

1. You have a right to receive services for which you are qualified. If requested, we will attempt to schedule services in a manner that minimizes your costs due to travel and/or loss of work time. If you are unable to pay for services, you may request to meet with someone that can help you in accesses services through this or another provider. No physical barriers will preclude treatment.
2. Services will be provided with a minimum of wasting time. The agency's operational hours will be reasonable convenient to all clients requesting services.

CONFIDENTIALITY

1. All information concerning you is held confidential and released only through procedures consistent with the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110/1-17], Health Information Portability and Accountability Act (HIPAA), and professional ethics. Your records can be subpoenaed by the Court without your permission.
2. You have a right to review and approve any information being requested by another provider giving service to you. You must sign a Consent for Release of Information for any such information to be sent.
3. You have a right to the confidentiality of information protected by the AIDS Confidentiality Act and AIDS Code. The following information is protected by the AIDS Confidentiality Act and AIDS Code:
 - a) a request for an/or signed consent to HIV antibody testing;
 - b) an individual's HIV antibody or AIDS status;
 - c) the fact that an individual has been tested for HIV antibodies, and/or the result of an HIV antibody test; and/or
 - d) participation is pre-test and/or post-test counseling.
4. Unless disclosure is authorized by statute and rule, no information protected by the AIDS Confidentiality Act and the AIDS Code shall be released by any member of the agency to other staff members and/or any other person unless you sign a consent for the release of the information.

NOTE: You are not required to tell any staff member whether you have been tested for HIV antibodies, and/or the result of any such test.
5. The agency is required by law to report any suspected child abuse and/or neglect.

6. The agency is required by law to report any suspected elder abuse and/or neglect.

TREATMENT

1. You have the right to an individual plan for treatment and will be expected to participate in your treatment planning. You may refuse treatment or any specific treatment and will be informed of the consequences resulting from a refusal of treatment and treatment procedure.
2. You have the right to know the name and professional credentials of anyone working with you, and due to the fact that UCCS works cooperatively with several departments at Southern Illinois University Carbondale, you may at some point in your treatment work with a student intern.
 - a. You may be asked if an intern can observe a session, and you have the right to refuse this request.
 - b. You may be assigned to work with an intern under the supervision of a licensed agency professional and you have the right to request alternate staff assignment.
 - c. If you are assigned to work with an intern, that intern will provide an informational page to you about his/her credentials, his/her supervisor's name and credentials, and his/her educational goals as an intern at UCCS.
3. You have the right to be:
 - a) treated with dignity and respect
 - b) free from psychological abuse including humiliation, threatening and exploiting action
 - c) free from physical/verbal abuse
 - d) free from sexual abuse/harassment
 - e) free from fiduciary abuse
4. You may request to participate in any staff meetings regarding yourself. You may be asked to attend pertinent clinical staffings regarding your treatment.
5. You may review your clinical records upon your written request. A staff member will be assigned to be with you during your record review. If you request a copy of information in your record, you will be charged photocopying fees. Records from other providers will not be released.
6. You have the right to be assigned a case manager who will advocate for you and who will assist you in obtaining services throughout your treatment program.
7. You will be advised of the positive effects and possible complications of any drugs or medication prescribed by any physician involved in your treatment. If medications are prescribed, you have the right to refuse specific medications.
8. Treatment will be provided in the least restricted environment.
9. An adult of sound mind has a right to make a declaration of preferences or instructions regarding mental health treatment as provided in the Mental Health Treatment Preference Declaration Act [755 ILLCS 43/1-75]. A Mental Health Preference Declaration is legal form you can create to give instructions about your mental health treatment, if you can't make those decisions yourself in the future. You may also name someone as your attorney-in-fact. That person can make your mental health decisions for you, or make sure the treatment instructions you put into your Declaration are followed. If you are interested in more information about creating a Mental Health Preference Declaration, a UCCS staff member can provide you with a guide booklet. If you decide you want a Declaration, you should talk about these decisions with a doctor and with a lawyer.
10. You have a right to know all of the risks and costs involved in the treatment, including the nature of treatment, possible alternative treatments, and the potential risks and benefits of the treatment

GRIEVANCE

1. If you feel your treatment has not been fair or reasonable, you may present your concerns in writing to the case manager assigned to you or to another employee of the agency. You are not required to use any specific form to document your grievance; however, if you request a form one will be provided to you. The case manager will meet with you within 10 working days for your written grievance to attempt to resolve the concerns expressed in your written grievance. If you are not satisfied with the outcome of the grievance hearing with your case manager, you may present your concerns in writing to the program coordinator. The program coordinator will meet with you within 10 working days to attempt to resolve the concerns expressed in your written grievance. If you are not satisfied with the outcome of the grievance hearing with the program coordinator, you may present your concerns in writing to the Executive Director of Union County Counseling Service, Inc. The Executive Director will meet with you within 30 days of receipt of your written grievance to try to resolve your concerns. The Executive Director's decision on the grievance shall constitute a final administrative decision, except when such decision is subject to review by the provider's governing body, in which case the governing board's decision is final. All alleged Human Rights Violations will be taken to the Board of Directors. You have the right to have your complaints acted upon.
2. A record of grievance or adverse decision appeal and the response thereto shall be maintained by the provider.
3. You have the right to legal recourse, if you believe you have been treated improperly; you have the right to confer with a family attorney, physician, clergyman, and others at any time.

ETHICS

UCCS has an Ethics Handbook for the purpose of identifying and educating persons to ethical or human rights issues in mental health care. The handbook provides a foundation of knowledge for understanding and respecting clients' rights as well as the ethical handling of a variety of possible situations, with the goals of improving quality of care, insuring clients' fullest participation in their care, and protection of clients rights. Clients may request of copy of the Agency's "Ethics Handbook" at any time. Concerns that a violation may have occurred may be brought to the attention of the treatment provider or any staff of the agency. All alleged violations will be fully investigated in accordance with policy.

EVALUATION

1. Consistent with providing professional and quality services, you will be given an opportunity to evaluate all aspects of your services and the personnel with whom you were involved. You will be asked to evaluate your treatment, in writing, during or upon completion of treatment.

AGENCY RESPONSIBILITIES

In addition to protecting client's rights, Union County Counseling Services, Inc. maintains responsibility for:

1. Assigning a therapist, counselor, case manager, and agency physician.
2. Deciding on the mode of treatment.
3. Assigning the frequency and duration of client involvement
4. Involving family members or significant others in treatment when appropriate.
5. Maintaining an accurate clinical record.
6. Making referrals to other service agencies.
7. Billing for services either directly, or through insurance or other third-party payees.
8. Defining criteria for termination of services.
9. Communicating with Courts or responsible officials thereof, as mandated by Statute, Rule, or Court decision.

PROTECTED RIGHTS

Union County Counseling Services shall ensure the following rights are protected in accordance with Chapter 2 of THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE.

1. The use of seclusion shall not be permitted.

2. You have the right to remain in treatment unless you voluntarily withdraw or meet criteria for termination.
3. You have the right to contact the Guardianship and Advocacy Commission, Equip for Equality, Inc., Human Rights Authority, Department of Human Services – Office of Mental Health, Department of Public Health, and Department of Children and Family Services.

The following are the address and telephone numbers to these agencies:

Guardianship and Advocacy #7 Cottage Drive Anna, IL 62906 618-833-4897	Equip for Equality, Inc. 1-800-758-0464	Human Rights Authority #7 Cottage Drive Anna, IL 62906 618-833-4897	Dept. of Public Health 2309 W. Main Marion, IL 62959 1-800-252-4343
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Department of Human Services 401 William Stratton Bldg. Springfield, IL 62765 217.785.6023	DCFS Industrial Drive, 108 Denny Anna, IL 62906 618-833-4449 800-252-2873	Office of Inspector General 901 Southwind Road Springfield, IL 62703 217-786-0019 800-368-1463
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4. This information will be given to you or your guardian in a language you understand.
5. Staff advisement of your rights and justification for any restriction of your rights will be documented in your record.
6. Every individual in treatment shall be free from abuse and neglect.
7. You or your guardian shall be permitted to purchase and use the services of private physicians and other mental health and developmental disabilities professionals of your choice. This shall be documented in your services plan.
8. You shall not be denied, suspended, or terminated from services or have services reduced for exercising any of your rights.

Rev. 11/3/15
 10/13 Rule 132
 Rev. 9/13 HIPAA Compliance
 Rev. 10/10
 Rev. 08/09
 Rev. 04/09
 Rev. 12/07
 REV: 12/06
 REV: 8/04
 REV: HIPAA Compliance 4/03
 REV: 10/31/00