Catholic Charities

Counseling Program

Client Rights, Responsibilities,
Program Policies & Treatment Consent

Client's Name: ______________________

Uses and Disclosures for Treatment, Payment, and Healthcare Operations

We may use or disclose your personal health information for treatment, payment, and healthcare operational purposes with your *written or oral authorization.* To help clarify these terms, here are some definitions:

- *Treatment* is when we provide, coordinate, or manage your healthcare and other services related to your healthcare. An example of treatment would be when we consult with other healthcare providers, such as your family physician or psychiatrist.
- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your personal health information to your health insurance carrier to obtain reimbursement for your health care or to determine eligibility or coverage.

Healthcare operations are activities that relate to the performance and operation of our services. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

CONSENT FOR TREATMENT. I hereby consent to receiving treatment as an Outpatient. These services may include; Crisis Intervention, Therapy/Counseling, Community Support, Mental Health Assessment, Treatment Plan Development, Review and Modification, Mental Health Case Management, and Client-Centered Consultation. Different therapeutic techniques may be utilized as alternative treatments during treatment; however, these will be explained to me prior to their implementation. Therapeutic services may be provided face-to-face or through distance counseling via phone therapy or a tele mental health platform. I authorize the services deemed necessary or advisable to address his/her/my needs.

Other Uses and Disclosures Requiring Authorization

We may use or disclose personal health information for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or healthcare operations, we will obtain an authorization from you before releasing this information.

Uses and Disclosures Without Authorization

We may use or disclose personal health information *without your consent* or authorization in the following circumstances:

- ***Child or Elder Abuse*** – If we have reasonable cause to believe a child may be abused or neglected; we must report this belief to the appropriate authorities. If you disclose any information during a counseling session that indicates that either you or someone else has physically or sexually abused a minor or elder, the therapist is required by law to report this information to the appropriate state agency. The therapist is also required by law to report reasonable suspicion of abuse, or if the child or elder is at imminent risk.
- ***Serious Threat to Health or Safety*** – If you communicate to the therapist a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures (including to police) that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary (including to police) to

protect you from harm.

- ***Judicial and Administrative Proceedings*** – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis, and treatment and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

Authorization for Release of Personal Health Information: I authorize use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Catholic Charities. I authorize Catholic Charities to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Catholic Charities 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 Catholic Charities for insurance benefits payable to me. I understand that I am financially responsible to Catholic Charities for any covered or non-covered services, as defined by my insurer.

CLIENT RIGHTS

As a client of, Catholic Charities Dioceses of Joliet Counseling Division you are entitled to the rights outlined in the Mental Health and Developmental Disabilities Confidentiality Act, Chapter 2 of the Mental Health and Developmental Disabilities Code, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These rights include, but are not limited to, the following:

1. You have the right to be provided mental health services in the least restrictive environment.
2. You have the right to be free from abuse, neglect and exploitation.
3. You have the right to have services provided to you following the development of an individualized treatment plan.
4. You have the right to have your treatment plan reviewed periodically, but at least once every six months.
5. You have the right to participate in the development and review of your treatment plan, when appropriate.
6. You have the right to be notified in writing of the side-effects of medication if your service includes the administration of psychotropic medication(s).
7. You have the right to refuse services, including medication, and to be informed of any consequences related to service delivery should you refuse medication.
8. You have the right to be free from physical restraint/seclusion, unless such restraint/seclusion is being used as a therapeutic measure to prevent you from causing physical harm to yourself or others.
9. You have the right to be notified of any client rights restriction(s) and to have your parent or guardian notified as well. If any of your client rights are restricted, justification of such rights restriction will be documented in your client record.
10. You have the right to contact the HFS, Guardianship and Advocacy Commission, Equip for Equality, Inc., and DCFS, DMHDD, or DOC or their designee(s). You have the right to be offered staff assistance in contacting these organizations and staff will provide you with the address and telephone number of any of the above agencies you wish to contact. You will also be informed of the process for reviewing grievances within HFS, DCFS, DMHDD, or DOC as applicable.

DuPage and Kendall Counties:
West Suburban Regional Office
P.O. Box 700
Hines, IL 60141-7009
FAX: (708) 338-7505
(708) 338-7500

Will, Grundy and Kendall Counties:
North Suburban Regional Office
99511 Harrison Avenue, FA 101
Des Plaines, IL 60016-1565
FAX: (847) 294-4263
(847) 294-4264

For Kankakee County:
East Central Regional Office
2125 South 1st St
Champaign, Illinois 61820
Fax (217) 278-5588
(217) 278-5577

ILLINOIS HEALTHCARE AND FAMILY SERVICES

Reporting Employee Misconduct www.illinois.gov/hfs/oig/Pages/ReportMisconduct.aspx
Reporting Fraud 1-844-453-7283 (1-844-ILFRAUD) or www.illinois.gov/hfs/oig/Pages/ReportFraud.aspx

11. You have the right to present grievances or to appeal adverse decisions related to your services. You have the Right to make such grievances or appeals to the highest level possible in the agency. This grievance process will be explained to you. A record of such grievances and the response to those grievances will be maintained.
12. You are entitled to have your rights explained to you using a language or method of communication you understand upon commencement of services.
13. You have the right not to have services denied, reduced, suspended, or terminated for exercising your rights.
14. You have the right not to be denied mental health services because of age, sex, race, religious beliefs, ethnic origin, marital status, physical or mental disability, or criminal record that is unrelated to present dangerousness.

PROGRAM POLICIES

Cancellations
Your therapist's time is a valuable commodity which is reserved for you alone at the time of your scheduled appointments. Please provide at least 24 hours' notice if you need to cancel or reschedule an appointment. Notifications can be made via phone or email, directly to your assigned Therapist or through the Intake Line (Phone: 815-723-0331 Email: counselingreferrals@cc-doj.org). Cancellations made less than 24 hours before your scheduled appointment time will be considered late cancellations. Not showing up for an appointment without prior notice will be considered a no-show.

All clients will be given a 10min grace period. Clients are considered late when they arrive 10min after scheduled appointments. It is at the discretion of the Therapist to reschedule the appointment for the same week, if their schedule allows. If the schedule does not allow and/or the client does not communicate that they will be late, the missed session will be considered a no show. Exceptions to the cancellation policy may be made in cases of emergencies or unforeseen circumstances, at the discretion of your Therapist. Please communicate any such situations as soon as possible. Clients with repeated late cancellations or no-shows may be subject to review and possible termination of services. Counselors will discuss any attendance concerns with clients to find a mutually agreeable solution.

Costs and Fees
The amount it actually costs Catholic Charities to provide one session of counseling is $200.00. If you are unable to pay the full cost, Catholic Charities will refer you to the State of Illinois insurance marketplace for you to apply for insurance and/or Medicaid benefits. If you do not qualify for Medicaid benefits, Catholic Charities may be able to place you on a sliding scale. Sliding Scale is based on your family income, dependents, and insurance application/denial. In order to receive sliding scale fee, you must bring required documentation with you to your first appointment, as requested when you call to request services. Your fee will be determined based upon a review of the sliding scale application and supporting documentation. If your insurance benefits or income changes at any time while you are a client of Catholic Charities Counseling Services, we will reevaluate your benefits or sliding scale application based on that new information. We verify insurance benefits and self-pay clients monthly. Late cancellations and no-shows may incur a fee $50.00.

Hours of Service
The Counseling Program office is open from 8:30am until 4:30 pm Monday through Friday. Actual appointment times are arranged with your therapist based on his or her available open hours and your schedule.

CLIENT RESPONSIBILITIES

Appointments
You have a responsibility to keep your scheduled appointments and to participate in your own treatment. We do understand there are emergencies but we ask that you please be mindful of the therapist's time. Three concurrent missed appointments without appropriate notification may result in the termination of your treatment and services.

Physical Examination
If a physical examination, evaluation for medication, and/or substance abuse evaluation is deemed necessary by your therapist, you are responsible for all associated costs.

Fees
You will be expected to pay the established fee at each session. Payment may be made by cash, check or credit card only. You will receive a receipt for each payment. If you cannot pay your fee, you will be expected to pay the fee at the next session. You cannot be more than two sessions behind and must pay something by the third session. If you cannot pay by the third session then you will be asked to reschedule the appointment and counseling will be put on hold until you can pay something towards your fee/balance.

Follow-Up Services
Your therapist will acquire your oral consent to contact you for follow up services by phone or email.

CONSENT

I, have read/been given my rights, responsibilities, and the agency's policies above. I consent to enter treatment through the Counseling Program of Catholic Charities, Diocese of Joliet and to abide by agency policies. I agree to pay fees as established by the intake department for each counseling session.

Client Signature/ Oral Consent ____________________ **Date:** ________

For Minors Only: I (we) represent that we are the parent(s) or legal guardian(s) of the above-named person, a minor. I (we) authorize and consent that our son/daughter receive treatment at Catholic Charities for his/her emotional difficulties.

Minor's Signature/ Oral Consent (*age 12 or above*): ____________________ Date: ________

Parent/Guardian Signature / Oral Consent *(for minor children)* ____________________ Date ________

As a staff member of this organization, 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.

Therapist Signature ____________________ **Date** ________

In the event of an emergency, I give my consent for a staff member of Catholic Charities to contact:

Name: ____________________ **Telephone Number(s):** ____________________