YOUTH & FAMILY COUNSELING
Opening doors to mental healthcare since 1962

Client Information

Date: _____

Client Name: _____ Date of Birth: _____ SEX: _____

Address: _____

City: _____

Zip Code: _____

Township: _____

Cell Phone: _____ Phone: _____

Is it okay to leave a message? ☐ Yes ☐ No

Would you like to accept text reminders? ☐ Yes ☐ No

If you would like to receive communication via email from YFC, please write your email below:

Email: _____

Please select all that apply to your race:

☐ American Indian/Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Prefer not to answer

Are you of Hispanic or Latino origin: ☐ Yes ☐ No ☐ Prefer not to answer

Number of people in your household: ____

Household income before taxes: (please select one box that applies):

☐ Less than $10,000 ☐ $10,000 to $29,999 ☐ $30,000 to $74,999
☐ $75,000 to $99,999 ☐ $100,000 to $149,999 ☐ $150,000 or more

Referred by: _____ Primary Care Physician: _____

Emergency Contact (if over 17)/Parent Name (if under 18)

Name: _____ Relationship: _____

Address: _____

Phone: _____ Phone: _____

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Insurance Information

The following information is needed to submit claims to your insurance.

A copy of your insurance card, front and back, will be copied by your therapist.

Date: _____

Client Name: _____ Client DOB: _____

Policy holder name: _____

Policy holder DOB: _____

Policy holder SSN: _____

Policy holder relationship to client: _____

Primary Insurance

Insurance Company Name: _____

Policy ID#: _____

Group #: _____

Insurance Phone Number (located on the back of your card): _____

Mental Health (MH) or Behavioral Health (BH) Phone Number: _____

Secondary/Supplemental Insurance

Insurance Company Name: _____

Policy ID#: _____

Group #: _____

Insurance Phone Number (located on the back of your card): _____

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Payment Agreement

Please select <u>one</u> of the following options:

□ My insurance plan is an **in-network insurance plan**. I understand that **Youth & Family Counseling (YFC)** is a preferred provider in my insurance network, and that I am responsible for charges not covered, charges applied to my deductible, and co-insurance or co-payments.

□ My insurance plan is an **out-of-network insurance plan**. I understand that YFC does not participate in my insurance network. I accept that YFC will bill my insurance, but I am responsible for charges not covered by my plan.

□ My insurance plan is a **Medicaid Managed Care Organization (MCO) in which YFC participates**. I understand that my insurance may not cover all charges and that I will be responsible for these charges.

□ My insurance plan is a **Medicaid Managed Care Organization (MCO) in which YFC does <u>not</u> participate**. I choose to be seen at YFC and understand that I am waiving my Medicaid plan coverage. YFC will <u>not</u> bill my insurance company and I am responsible for all charges incurred. I may apply for a reduced fee.

□ I am not covered by, or choose not to use, insurance. I understand that I am responsible for all charges incurred, and that I may apply for a reduced fee.

Please initial all acknowledgements:

_____ I authorize the use and disclosure of my personal health information for the purposes of obtaining payment for my care. This includes the minimally necessary information for the filing of insurance claims. I authorize direct payment/assignment of insurance benefits to YFC.

_____ I understand that payment is expected at the time of service or when a balance due is presented on my monthly statement. I understand that if my account balance becomes overdue, services may be discontinued and I may face collection action.

_____ I understand that I will be charged if I fail to show up for a scheduled appointment. I will also be charged for each appointment cancelled with less than 24 hours notice.

_____ _____

Client Signature Date Witness Date

_____

Parent/Guardian Signature Date

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Client Consent, Acknowledgement & Authorization

Please initial all acknowledgements:

_____ **Consent for Treatment**
I hereby consent to the treatment provided by **Youth & Family Counseling (YFC)** and its therapists. I authorize the mental health care services deemed necessary or advisable by my caregivers to address my needs.

_____ **Consent for Telehealth Treatment**
I hereby consent to the telehealth treatment provided by YFC and its therapists. I acknowledge I have been offered and/or received a copy of YFC's Telehealth Consent and agree to abide by terms of treatment. All my questions have been answered.

_____ **Client Rights & Responsibilities**
I acknowledge I have been offered and/or received a copy of YFC's Client Rights and Responsibilities statement and agree to abide by terms of treatment.

_____ **HIPAA Notice of Privacy Practices**
I acknowledge I have been offered and/or received a copy of YFC's Notice of Privacy Practices.

_____ **Cases of Divorce or Separation**
In cases of divorce or separation, the parent or guardian who brings the child to the appointment is responsible for payment. Payment (co-pays, deductibles, etc.) are due at the time of service regardless of which parent is responsible for medical coverage. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the attending parent's responsibility to collect from the other parent.

Authorization to Coordinate Care with My Physician (PCP):

_____ I authorize my therapist to contact and communicate with my Physician for the purpose of coordinating care. I understand that my therapist will only share minimally necessary information and will review with me when information will be shared, what information will be shared, and for what purpose. I also understand that I may revoke this Authorization at any time in writing.

OR

_____ I do not authorize communication with my Physician. YFC will not refuse to treat me based on whether I agree to these contacts. Reason for Refusal: _____

_____ _____
Client Signature Date Witness Date

_____
Parent/Guardian Signature Date

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Credit Card Authorization

Client Name: _____

Cardholder Name: _____

I hereby authorize Youth & Family Counseling to charge the credit card that I have provided to the clinician for the amount due according to Youth & Family Counseling billing policies, in compliance with the obligations set forth in the Payment & Insurance Agreement.

This authorization will remain in effect until cancelled in writing.

_____

Cardholder Signature Date

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Telehealth Consent

Telehealth Informed Consent

Teletherapy/telehealth is the delivery of behavioral health services/psychotherapy using interactive technologies (i.e. telephone, video) between Youth & Family Counseling (YFC) psychotherapists and a client who is not in the same physical location.

This form is an addition/addendum to the consents given at the beginning of treatment.

Consent for Treatment

- I hereby consent to telehealth (telephone, video) treatment provided by YFC and its therapists. I authorize the mental health care services deemed necessary or advisable by my caregivers to address my needs. This agreement shall be in effect for the duration of my treatment at YFC. I have the right to withdraw my consent to teletherapy at any time.
- I understand that I may benefit from telehealth services but that results cannot be guaranteed or assured.
- I understand that-YFC cannot provide telehealth services to me if I am outside of Illinois, as YFC is licensed to deliver telehealth services to clients who are within the State of Illinois only.

Privacy and Confidentiality

Laws that protect the confidentiality of my medical information also apply to telehealth services.

- I acknowledge that YFC is committed to the highest standard of practice and uses the secured HIPAA compliant platform in the delivery of telehealth services. Privacy and security of health information and data management for this platform is found here (https://zoom.us/docs/en-us/privacy-and-security.html).
- I understand that there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties inherent with communication systems.
- I understand that I have a responsibility to maintain session privacy on my end (e.g. physical space free from distraction and interruption, updated security measures on my device, etc.).
- I understand that I am not allowed to make an audio or video recording of any portion of my telehealth sessions.

Technology

- I understand that I will need access to and familiarity with the appropriate technology in order to participate in telehealth services. This includes downloading an application and/or software to use the platform as well as video/audio and Internet services.
- I understand I am responsibility for charges from my data plans.
- I understand that technology may fail before or during services, that the transmitted information in any form may be unclear or inadequate for proper use, and that information may be intercepted by an unauthorized person.
- I understand that my provider or I may discontinue the telehealth session if it is felt that the video connection and/or environment are not adequate for effective therapy.
- If video services are not available due to an unplanned equipment or service malfunction, I understand that sessions will occur via telephone. In the event of a disruption in video service, my therapist will contact me using the primary/preferred telephone number in my YFC file

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Telehealth Consent

Emergency

YFC telehealth is not a crisis-based clinical service.

- I agree that certain situations, including emergencies and crises, are inappropriate for telehealth psychotherapy services. If I am in a crisis or emergency situation, I will immediately call 911 or go to the nearest hospital.
- I understand that emergency situations include: having thoughts about hurting or harming myself or others; experiencing uncontrolled manic or psychotic symptoms; any medical or life-threatening emergency, including abusing drugs or alcohol in a dangerous way.
- Per YFC policy, if my provider deems me to be in a life threatening or unsafe condition, my provider will contact 911 and/or my emergency contact immediately.

Payment

YFC is not able to guarantee that your insurance plan will pay for telehealth services. Please select **one** of the following telehealth options:

- ☐ I want telehealth services. **I agree to pay YFC for services rendered and request that YFC submit for reimbursement from my insurance company.** I understand that if my insurance does not pay, then I am responsible for payment. If my insurance does pay for rendered services, YFC will refund any payments made, less co-pays and deductibles.
- ☐ I want telehealth services. **I am not covered by, or choose not to use, insurance.** I understand that YFC will <u>not</u> bill my insurance company. I understand that I am responsible for all charges incurred and that I may apply for a reduced fee.
- ☐ I do not want telehealth services.

- I authorize the use and disclosure of my personal health information for the purposes of obtaining payment for my care. This includes the minimally necessary information for the filing of insurance claims. I authorize direct payment/assignment of insurance benefits to YFC.
- I understand that payment is expected at the time of service or when a balance due is presented on my monthly statement. I understand that if my account balance becomes overdue, services may be discontinued and I may face collection action.
- I understand that I will be charged for sessions longer than 16 minutes, even if the session is terminated early due to service interruption and/or technology.
- I understand that I will be charged if I fail to show up for a scheduled appointment. I will also be charged for each appointment cancelled with less than 24 hours notice.

I have read and understand the information provided above. All my questions have been answered.

_____
Client Name

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

Notice of Privacy Practices

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.

Rights Regarding Your Health Information

You have the following rights under Illinois and Federal Law:

- ***Right to Inspect and Copy.*** You have the right to inspect your Clinical Record, however, we may request that this review be done with your therapist or the Director of Clinical Services. You may request a copy of your Clinical Record. (You will be charged a reasonable fee for copying and postage.) The original Clinical Record is the property of **Youth & Family Counseling (YFC)** and is never released.

- ***Right to Release Clinical Record and Protected Health Information.*** You may consent in writing to release a copy of your Clinical Record. Your consent is revocable at any time, but only applies to future disclosures and not to disclosures previously authorized. Except as described in this Notice or as required by Illinois and Federal law, we cannot release your protected health information without your written consent.

- ***Right to Request Confidential Communication.*** You have the right to ask us to communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only by sending materials to a P.O. Box instead of your home address, or you may ask us to only call your cell phone. We will not ask the reason for your request and will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

- ***Right to Amend Clinical Record.*** If you believe that something in your record is incorrect or incomplete, you may request that we amend it. To do this, contact the Director of Clinical Services. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We are not obligated to make all requested amendments, but will give each request careful consideration. If your request is denied, you have a right to file a statement outlining your disagreements or objections with us. This statement will be attached to your Clinical Record.

- ***Right to an Accounting of Disclosures or a Breach of Security.*** You have the right to ask us for an accounting of disclosures. This is a listing of those individuals or entities that have received your health information. The listing will not cover health information that was given to you or your personal representative or to others with your permission. It will not cover health information that was given in order to provide care for you, facilitate payment for you healthcare services, and assist YFC in its operations. And it will not include information we are required to release by law or court order.

  To receive information regarding disclosure made for a specific time period (no longer than six years), please submit your request in writing to the Director of Clinical Services. We will notify you of the cost involved in preparing this list. Please note that Clinical Records are only kept for seven years after therapy is terminated for adults, and for seven years after the age of majority (age 18) for minors. After that point they are destroyed.

You have a right to be notified if there is a breach of your unsecured protected health information. This would include information that could lead to identity theft. You will be notified if there is a breach or a violation of HIPPA Privacy Rule and there is an assessment that your protected information may be compromised.

Use and Disclosure of Protected Health Information

In order to effectively provide you with care, there are times we need to share your health information with others outside of YFC. These include:

- ***For Treatment.*** We may use or disclose your health information to provide, coordinate, or manage your counseling, therapy and related services. For example, your health information may be shared with a physician or other health care providers who are also caring for you.

  However, under Illinois law, except in emergency situations, we cannot release your health information without your consent. We will discuss situations where we would like to share your health information and request your written consent to do so. These consents specify the person or agency to whom information will be shared, the purpose or need for information, what information will be shared and time limitations. Your consent can be withdrawn at any time and you have the right to inspect and request a copy of any written information to be released. Emergency situations include those where there is a risk to health or safety for you or others.

  For minors under the age of 12, the minor's parent, guardian, or agent under health care power of attorney may authorize disclosure of information. Children over 12 and under 18 will be informed and asked if they object to disclosure of information. If they object, their protected health information will not be released. In addition, the minor's therapist may find that there are compelling reasons for denying access to or release of information, and may therefore deny release. Compelling reasons include but are not restricted to the clinical best interest of the minor or legal custody conflict where independent evaluations can be sought elsewhere that would not compromise the therapy relationship with the minor.

- ***For Payment.*** We may use and disclose your health information so that the treatments and services you receive may be billed and payment may be collected from you, an insurance company or a third party. As part of our intake process, we will ask your verbal permission to contact your insurance carrier to verify coverage and to obtain authorization for services. If insurance is involved, once you become a client of YFC, you will be asked to give us written authorization to submit claims on your behalf. In processing insurance claims, YFC is committed to providing only the minimally necessary information required. You have a right to restrict certain disclosures of your protected health information to your health plan, if you pay out of pocket in full for the services provided to you.

- ***For Healthcare Operations.*** We may use or disclose your health information in connection with our health care operations, including but not limited to the following: quality assessment and improvement; functions related to therapy such as scheduling appointments; or professional training, accreditation, certification, licensing or credentialing.

- ***For Individuals Involved in Your Care or Payment for Your Care.*** With your written consent, we may disclose the minimally necessary information about you to your family or other persons you

identify who are involved in your care, or who help pay for your care.

In an emergency situation, we may exercise our professional judgment to determine whether a communication about you is in your best interest, who is the appropriate person to contact, and what health information is relevant to their involvement in your health care. If you have identified an emergency contact person, every effort will be made to contact that person first.

- ***To Avert a Serious Threat to Health or Safety.*** As required by law, we may disclose health information about you when necessary to prevent a serious threat to your health or safety or the health and safety of others. Any disclosure of this kind, however, would be made only to someone able to help prevent the threat.

- ***Other Communications with You.*** We may use and disclose your health information to contact you at the address and telephone number(s) you give us about scheduled or canceled appointments, registration or insurance updates and billing and/or payment matters. Unless you tell us otherwise, we may leave messages about appointments or other reminders on your telephone or with a person who answers the phone.

- ***As Required by Law.*** We may disclose your health information if court ordered. Your health information is not subject to subpoena without a court order, however, all providers at YFC are mandated reporters. They are required by law to report suspected abuse and neglect of children or the elderly. They are required to warn and protect when they believe there is an immediate danger of harm or danger to someone, including domestic violence. Mandated reporting could involve the police and law enforcement. If a crime is committed on our premises or against our staff we may share information with the police and law enforcement to apprehend the criminal.

- ***Criminal Activity and Threats of Danger to Others—Present and Past.*** We may share information with law enforcement to help apprehend a criminal if a crime is currently occurring, is committed on our premises, or against our staff. We also have the right to involve law enforcement when we believe an immediate danger exists to some identifiable person and may imminently occur. However, past criminal activities shared in therapy are protected by confidentiality and will not be disclosed without your written permission.

- ***Health Oversight Activities and Specialized Government Functions.*** We may disclose information to governmental health oversight authorities or agencies for activities authorized by law, such as audits, investigations, or inspections of clinical records by Medicare or licensure boards. When services are funded by the government, we may disclose information for the coordination of your care.

- ***Coroners or Medical Examiners.*** We may release health information about you to a coroner or medical examiner as necessary to identify a deceased person or to determine the cause of death.

- ***Fundraising.*** We will *not* use your health information, e.g., name, address or telephone numbers, to solicit contributions. We will not sell protected client health information for any marketing reason. You will have the opportunity to opt in or opt out of receiving communications from YFC that may include solicitations for contributions.

Questions and Complaints

If you have any questions or wish to lodge a complaint, you may contact the Director of Clinical Services or Executive Director**.** All complaints must be submitted in writing.

Christine Spuhler, Director of Clinical Services or
Janelle Moravek, Executive Director
1113 S. Milwaukee Ave, Suite 104
Libertyville, IL 60048

If you believe YFC has violated your privacy rights, you may also contact any of the following:

U.S. Department of Health and Human Services Office for Civil Rights at 312-886-2359
Illinois Guardianship & Advocacy Commission at 312-793-5900 or 312-793-5397 (TDD)
Illinois Human Rights Authority North Suburb Regional Authority at 866-274-8023
Illinois Department of Human Rights at 312-814-6200 or 217-785-5125 (TDD)

We will not retaliate against you for filing a complaint.

If you wish additional copies of this policy, you may ask for one from your therapist or the front desk.

Changes in Policy

YFC reserves the right to change its *Notice of Privacy Practices* based on the needs of the organization and changes in state and federal law.

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Client Rights & Responsibilities

As a client, you have the right:

- To considerate and respectful care.
- To be informed of your rights and have them explained in language that you understand.
- To receive care without regard to your age, race, color, creed, national or ethnic origin, religion, gender, marital status or lifestyle, mental or physical disability, sexual orientation, HIV status, or criminal record.
- To receive nondiscriminatory access to services in accordance with the Americans With Disabilities Act.
- To know the identity of those involved in your care -your therapist, their supervisor, and the Director of Clinical Services.
- To know the costs of therapy, insofar as they are known. To apply for a need-based fee reduction, based on your income, the size of your family, and YFC's sliding fee scale. (Note: Reduced-fee services are made possible through grants and charitable donations and may be limited by the amount of funding available to YFC.)
- To expect that all communications and records pertaining to your care will be treated as confidential, except in cases of suspected abuse, neglect, or safety where disclosure is required and/or permitted by law.
- To expect that your privacy will be respected. You will be asked to identify those who you consent to know that you are in therapy. Otherwise, we will not acknowledge that you are a client here.
- To be involved in the decisions regarding your care and therapy. This includes making informed consent and decisions regarding your care. You have a right to accept or refuse recommended treatment. YFC may choose to not offer you services if you refuse needed care.
- To express complaints or grievances concerning the quality of care or services and to receive a response to your complaint.
- To expect that efforts will be made to provide you with continuous, coordinated, and appropriate care.
- To review the Clinical Records pertaining to your therapy, to have the information explained or interpreted as necessary, and to have a copy of the records.
- To receive care in a safe environment.
- To expect that your treatment preferences will be responded to as delineated in your Mental Health Advance Directive, if you have one.

Client Rights & Responsibilities

As a client, it is your responsibility:

- To provide all personal and health information needed to provide you with appropriate care.
- To participate to the best of your ability in making decisions about your care, and to comply with the agreed upon plan of care.
- To ask questions of your therapist when you do not understand any information or instructions.
- To maintain appointments as scheduled, or to reschedule in a timely fashion. Cancellations without twenty-four hours notice will be charged to you, and are not covered by insurance plans. (Poor attendance will result in the loss of your regularly reserved appointment time.)
- To inform your therapist if you anticipate problems in following recommended treatment.
- To inform your therapist if you desire a transfer of care to another therapist.
- To be considerate of others receiving or providing care at YFC.
- To supervise your children. Children 12 years and younger should not be left unattended at any time. YFC will not supervise unattended children. A parent or caretaker is expected to remain in the building during your child's session. At the conclusion of your child's session, the therapist will escort him/her back to the waiting area to meet you.
- To accept financial responsibility for your therapy by providing payment at the time of service, working cooperatively to resolve any financial obligations you may have, authorizing YFC to file claims on your behalf and accept assignment of benefits, and notifying YFC immediately if your insurance coverage changes.
- To respect YFC's appointment policies as outlined below:
    - Your therapist will meet you at your appointment time. If he or she does not meet you promptly, let the staff know you are waiting by ringing the bell.
    - We see clients by appointment only.
    - We do not interrupt counseling sessions.
    - We do not offer same-day appointments or walk-ins.
    - We are not a crisis center. If you are experiencing an emergency, please go to the nearest Emergency Room or call 911.