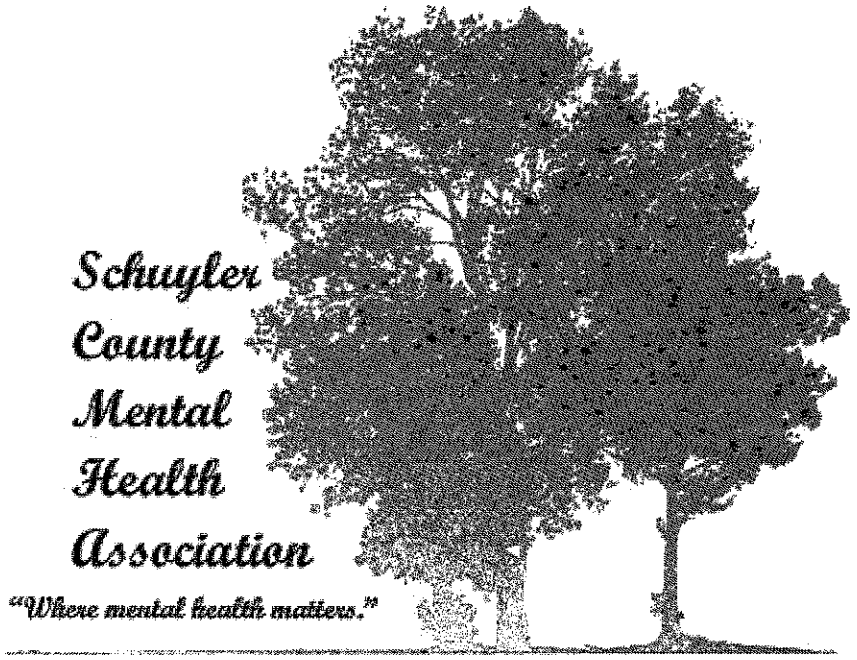

Adult Mental Health Handbook

Schuyler County Mental Health Association
127 South Liberty Street
Rushville, IL 62681

Telephone: 217-322-4373
Fax: 217-322-2138

Client Information

Client Name:	Client Preferred Name:
DOB:	☐ Male ☐ Female
Phone #:	SS #:
Address:	City, State, Zip:

Client Information (Responsible Party Other Than Client) ☐ **Same as Above**

Name:	Phone #:
Address:	City, State, Zip:

Insurance/Medicaid/Medicare Information

Name of Primary Insurance:	Member ID #:
Group #:	Medicare #:
Medicaid #:	Policy Holder Name:
Address:	City, State, Zip:
Phone #:	SS #:
DOB:	☐ Male ☐ Female
Employer:	
Relationship to Policy Holder: ☐ Self ☐ Child	☐ Spouse ☐ Other (Please Specify)

Name of Secondary Insurance:	Member ID #:
Group #:	Medicare #:
Medicaid #:	Policy Holder Name:
Address:	City, State, Zip:
Phone #:	SS #:
DOB:	☐ Male ☐ Female
Employer:	
Relationship to Policy Holder: ☐ Self ☐ Child	☐ Spouse ☐ Other (Please Specify)

Emergency Contact

Name:	Phone #:

ALL CO-PAYMENTS, COINSURANCE, DEDUCTIBLES AND SELF-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED. FAILURE TO PROVIDE/LIST OR OTHERWISE IDENTIFY INSURANCE COVERAGE OR CHANGES IN INSURANCE COVERAGE WHEN IT OCCURS, CAN RESULT IN SERVICE FEES. I REALIZE I WILL BE RESPONSIBLE FOR PAYMENT REGARDLESS OF THIRD PARTY INSURANCE PAYMENTS.

Guarantor Signature and Date

Witness Signature and Date

SCHUYLER COUNTY MENTAL HEALTH ASSOCIATION

Handbook Receipt for the Mental Health and Substance Abuse Program

I have received a copy of the Schuyler County Mental Health and Substance Abuse Program Handbook and am aware of my rights and responsibilities, including my rights governing the confidentiality of my record. I have also been given a copy of my Client Rights.

Should I have any questions about the information in the handbook I will ask my Counselor.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Place this form in the clinical record of the client.

CLIENT RIGHTS

1. You have the right to maintain all of your legal and civil rights.
2. You have a right to receive all services regardless of your sex, race, religion, ethnicity, disability, age, financial status, sexual orientation, HIV status, or previous criminal record
3. You are entitled to adequate and humane care and services in the least restrictive environment.
4. You have a right to participate in the development of your own individualized treatment plan and to receive a copy at your request and to participate in any treatment team meeting regarding yourself.
5. All information concerning you is held confidential, governed by the federal Confidentiality Act for Substance Abuse services and the Mental Health and Developmental Disabilities Confidentiality Act, and will only be released by your written consent or by court order.
6. You have a right to review your clinical record under the supervision of the counselor.
7. Justification for any restriction of your individual rights shall be documented in your individual record.
8. You have the right to express any grievances and to appeal adverse decisions of the agency in writing to the Agency Administrator. If you still do not feel satisfied, you may send a written grievance to the Agency Board of Directors for discussion at their next meeting. This shall constitute a final administrative decision and shall be subject to review in accordance with the Administrative Review Law.
9. You or your guardian have the right to refuse treatment or any specific treatment procedure. If treatment is refused, you have a right to be informed of alternative services and the possible consequences resulting from any such refusal.
10. You have the right to terminate treatment at any time, and you shall not be denied, suspended or terminated from services or have services reduced for exercising any of your rights.
11. You have the right to be free from abuse, neglect, and exploitation. Any incidents of abuse, neglect or exploitation should be reported to the IL Department of Public Health, IL Department of Human Services, (Mental Health Section or Substance Abuse Section), or the IL Department of State Police for investigations.
12. You have the right to report any infringements of your rights to you agency's human rights committee. You have the right to request agency staff assistance in contacting the agencies listed below:

Guardianship and Advocacy Commission (GAC)
421 East Capital Street
Springfield, IL 62701
217-785-0645

Equip for Equality, Inc.
427 East Monroe Street
Springfield, IL 62701
217-544-0464

Dept of Human Services-Mental Health Div.
402 South Spring Street
Springfield, IL 62765
217-782-6154
800-843-6154

Dept of Human Services-Substance Abuse Sec
622 East Washington
PO Box 19429
Springfield, IL 62794
217-782-0686

Office of Inspector General 800-368-1463

13. An HIV antibody or AIDS test cannot be required as a condition of treatment, and you cannot be required to sign an authorization for "Release of Information" concerning your HIV antibody test or HIV or AIDS status as a condition of treatment. You are not required to disclose whether you have been tested for HIV antibodies and/or the result of any such test.

    Any individual who wishes to be tested for HIV antibodies must be informed that he/she may undergo testing on an anonymous basis. Unless disclosure is otherwise authorized be statue and rules, no information governed by the AIDS Confidentiality Act and the AIDS Code shall be released by an organization or any member of its staff to

other staff members including, but not limited to, the organization's Executive Director, Medical Director, and/or any other person or entity unless and until the individual in question has signed a legally effective Release of Information form, in accordance with the statute and rule.

14. Staff will assist you with voter registration if you are not a registered voter.
15. You have the right to have these explained to you in a language you can understand.
16. You have the right to non-discriminatory access to services in accordance with the American Disabilities Act (ADA) of 1990.

CONSUMER RESPONSIBILITIES

You agree to accept the following responsibilities:

1. To keep all scheduled appointments with your counselor.
2. To be punctual; understanding that arrival a minimum of fifteen (15) minutes late for an appointment can be considered a missed appointment and you will be asked to reschedule.
3. To give 24 hour notice if you must cancel your appointment.
4. To be free of alcohol and drugs at the time of your appointment.
5. To participate in your treatment and the development of your treatment plan. (This includes presenting required documentation. Failure to bring required documentation will result in the cancellation of an appointment and you will be asked to reschedule.)
6. To maintain the confidentiality guidelines set forth in any group activity in which you may participate.
7. To recognize that your treatment may be terminated for failure to participate in treatment. NOTE: Four failed/cancelled appointments can be viewed as failure to participate.

Signature is required for clinical records only.

I _____, have reviewed my rights and have received a copy of such.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

I have explained the consumer rights to the consumer and believe he/she has an understanding of these rights.

_____ _____

Witness Signature Date

SCHUYLER COUNTY MENTAL HEALTH ASSOCIATION

Notice of Funded Services

Per the Health Insurance Portability and Accountability Act (HIPAA) and the requirements in the Department of Human Services/Department of Mental Health Provider Manual, you are hereby informed that all individuals who receive Mental Health services, funded in part or in whole by the state, have their name and demographics reported to the Department of Human Services/Department of Mental Health as the payer of the services. This information is retained in the Department of Human Services/Department of Mental Health information database.

I acknowledge that I have read the above information:

_____ _____

Signature Date

SCHUYLER COUNTY MENTAL HEALTH ASSOCIATION

Consent for Service

I authorize and consent that _____ will receive Mental Health and/or Substance Use Prevention and Recovery services from Schuyler the Schuyler County Mental Health.

The nature and purpose of the service, the possible alternatives to such service, and the possible consequences have been fully explained to me. I understand that no guarantee has been given as to the results of the service.

I understand that the case record maintained by the Schuyler County Mental Health will be kept absolutely confidential. Any disclosure, except as the law may require, must be approved by me in writing. Knowing or willing violation of this assurance is subject to prosecution as a Class A misdemeanor.

This consent for service is revocable by either party through verbal or written notice. In such instances, the case will be closed and maintained for possible future use. After closing the case, all information contained therein will still remain confidential and any disclosure, except as the law may require, must be approved by me in writing. If my treatment plan indicates that I speak with the Psychiatrist, I agree to keep monthly contacts with my counselor.

I understand that I have the right to expect quality professional services. If I am unhappy with the services or the policies of the program, I may make a complaint or file a consumer grievance. For example, I may want a different counselor, I may think the fee is too high, I may believe the scheduling of appointments is too difficult, etc.

If I have a complaint, I should discuss it first with my counselor. If it is still not resolved, I may discuss it with the Agency Administrator. (The Agency Administrator would like to receive the complaint in writing.) If I still do not feel satisfied, I may send a written grievance to the Agency Board of Directors for discussion at their next meeting.

I have the right to be free from abuse and neglect.

_____	_____
Client Signature	Witness
_____	_____
Date Signed (by Client, Guardian, or Conservator)	Title/Credentials
_____	_____
Address & Phone # (If Guardian or Conservator)	Date Signed by Witness

The following persons are entitled to inspect a client's record or any part thereof:

- The client if he/she is 12 years of age or older.
- The parent or guardian of a client who is under 12 years of age.
- The parent or guardian of a client who is at least 12, but under 18 years of age if the client is informed and does not object.
- The guardian of a client over 18 years of age.

Schuyler County Mental Health Center
Notice of Privacy Practices (Substance Abuse/Mental Health)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. Protected Health Information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. The confidentiality of alcohol and drug abuse patient records is specifically protected by Federal law and regulations. The confidentiality of mental health patient records is specifically protected by state law. The Schuyler County Mental Health Center is required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the program that you attend the program, or disclosing any information that identifies you as an alcohol or drug abuser or mental health patient. The violation of these laws or regulations by this program is a crime. If you suspect a violation you may file a report to the appropriate authorities in accordance with applicable law.

How We May Use and Disclose Health Information About You

- For Treatment. We may use medical and clinical information about you to provide you with treatment or services.
- For Payment. We may use and disclose medical information about you so that we can receive payment for the treatment services provided to you if you are receiving substance abuse treatment services, this will only be done with your authorization.
- For Health Care Operations. We may use and disclose your PHI for certain purposes in connection with the operation of our program.
- Schuyler County Mental Health participates with other behavioral health services agencies (each, a "Participating Covered Entity") in the IPA Network established by Illinois Health Practice Alliance, LLC. Through Company, the Participating Covered Entities have formed one or more organized systems of health care in which the Participating Covered Entities participate in joint quality assurance activities, and/or share financial risk for the delivery of health care with other Participating Covered Entities, and as such qualify to participate in an Organized Health Care Arrangement ("OHCA"), as defined by the Privacy Rule. As OHCA participants, all Participating Covered Entities may share the PHI of their patients for the Health Care Operations purposes of the OHCA.
- Without Authorization. Applicable law also permits us to disclose information about you without your authorization in a limited number of other situations, such as with a court order. These situations are explained on the following pages.
- With Authorization. We must obtain written authorization from you for other uses and disclosures of you PHI.

Your Rights Regarding Your PHI. You have the following rights regarding PHI we maintain about you:

- Right of Access to Inspect and Copy. You have the right, which may be restricted in certain circumstances, to inspect and copy PHI that may be used to make decisions about your care. We may charge a reasonable, cost-based fee for copies.
- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of the disclosures that we make of you PHI.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

- Complaints. You have the right to file a complaint in writing to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. *We will not retaliate against you for filing a complaint.*

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information ("PHI") in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice of Privacy Practices by sending a copy to you in the mail upon request, or providing one to you at your next appointment.

How We May Use and Disclose Health Information About You

Listed below are examples of the uses and disclosures that Schuyler County Mental Health Center may make of your PHI. These examples are not meant to be exhaustive, but describe the types of uses and disclosures that may be made.

Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations

Treatment. Your PHI may be used and disclosed by your physician, counselor, program staff and others outside of our program who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and any related services. This includes coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care treatment. For example, your protected health information may be provided to the state agency that referred you to our program to ensure that you are participating in treatment. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of the program, becomes involved in your care. Except for emergency services, we will not send your PHI to an outside health care provider who is caring for you unless you give us written authorization to do so.

Payment. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If you are in a substance abuse treatment program, we will not use your PHI to obtain payment for your health care services without your written authorization. If you are in a mental health program, we may use you PHI to obtain payment for your health care services without your written authorization.

Healthcare Operations. We may use or disclose, as needed, your PHI in order to support the business activities of our program including, but not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician or counselor. We may also call you by name in the waiting room when it is time to be seen. We may share your PHI with third parties that perform various business activities (e.g., billing or typing services) for Schuyler County Mental Health Center, provided we have a written contract with the business that prohibits it from re-disclosing your PHI and requires it to safeguard the privacy of your PHI.

We may contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures That Do Not Require Your Authorization

Required by Law. We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Health Oversight. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Child Abuse or Neglect. We may disclose you PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the initial mandated report. By law we are mandated to report information to DCFS (or other authorities) regarding abuse or neglect.

Deceased Patients. We may disclose PHI regarding deceased patients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Criminal Activity on Program Premises/Against Program Personnel. We may disclose your PHI to law enforcement officials if you have committed a crime on program premises or against program personnel.

Court Order. We may disclose your PHI if the court issues an appropriate order and follows required procedures.

Interagency Disclosures. Limited PHI may be disclosed for the purpose of coordinating services among government programs that provide mental health services where those programs have entered into an interagency agreement.

Public Safety. If you are in a mental health treatment program only, we may disclose PHI to avert a serious threat to health or safety, such as physical or mental injury being inflicted on you or someone else.

Uses and Disclosures of PHI With Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization at any time, unless the program or its staff has taken an action in reliance on the authorization of the use or disclosure you permitted.

Your Rights Regarding Your Protected Health Information

Your rights with respect to your protected health information are explained below. Any requests with respect to these rights must be in writing. A brief description of how you may exercise these rights is included.

You have the right to inspect and copy your Protected Health Information.

You may inspect and obtain a copy of PHI that is contained in a designated record set for as long as we maintain the record. A "designated record set" contains medical and billing records and any other records that the program uses for making decisions about you. Your request must be in writing, except if you are in a mental health treatment program in which case we will accept a verbal request. We may charge you a reasonable cost-based fee for the copies We can deny you access to your PHI in certain circumstances. In some of those cases, you will have a right to appeal the denial of access. Please contact our Privacy Officer if you have questions about access to your medical record.

You may have the right to request amendment of your Protected Health Information.

You may request, in writing, that we amend PHI that has been included in a designated record set. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of it. Please contact the Schuyler County Mental Health Center Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of some types of Protected Health Information disclosures.

You may request an accounting of disclosures for a period of up to six years (excluding disclosures made to you, made for treatment purposes, made as a result of your authorization, and certain other disclosures). We may charge you a

reasonable fee if you request more than one accounting in any 12-month period. Please contact our Privacy Officer if you have questions about accounting of disclosures.

You have a right to receive a paper copy of this notice.

You have the right to obtain a copy of this notice from us. Any questions should be directed to our Privacy Officer.

You have the right to request added restrictions on disclosures and uses of your Protected Health Information.

You have the right to ask us not to use or disclose any part of your PHI for treatment, payment or heath care operations or to family members involved in your care. Your request for restrictions must be in writing and we are not required to agree to such restrictions. Please contact our Privacy Officer if you would like to request restrictions on the disclosure of your PHI.

You have a right to request confidential communications.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable, written requests. We may also condition this accommodation by asking you for information regarding how payment will be handled or specification of an alternative address or other method of contact. We will not ask you why you are making the request. Please contact the Privacy Officer if you would like to make this request.

Complaints

If you believe we have violated your privacy rights, you may file a complaint in writing to us by notifying our Privacy Officer, at 127 S. Liberty Street, Rushville, IL, 217/322-4373. We will not retaliate against you for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services as follows:

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0257

The effective date of this Notice is April 14, 2003.

SCHUYLER COUNTY MENTAL HEALTH ASSOCIATION

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name _____

DOB _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Schuyler County Mental Health's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lyndi Smith, Privacy Officer.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of a Client, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.

FOR STAFF USE ONLY:

☐ Client Refuses to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date

SCHUYLER COUNTY MENTAL HEALTH ASSOCIATION
127 South Liberty Street, Rushville, IL 62681
Phone: 217-322-4373 Fax: 217-322-2138
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, (Print Name) _____ request/authorize Schuyler County Mental Health Assn.

☐ to OBTAIN from:

☐ DISCLOSE to: _____
Name of Agency/Person **Address, City, State, ZIP**

ALL of the following information from records in its possession as marked for:

_____
Name

Dates of Service Requested:
_____

_____ _____
Date of Birth **Address, City, State, ZIP**

____☐ *Clinical Assess. Summary*	____☐ *Psychological Report*	____☐ *Psychological History*
____☐ *Summary & Recommendations*	____☐ *Diagnosis & Prognosis*	____☐ *Psychiatric History*
____☐ *DUI/AODA Eval/Recommendations*	____☐ *Substance Use History*	____☐ *Medical History*
____☐ *Entire Record*	____☐ *Other (Specify)*_____	

FOR THE PURPOSE OF:

____☐ *Transfer of treatment to another agency or provider*	____☐ *Court Testimony*
____☐ *Consultation with other persons involved in treatment process*	____☐ *Other:*_____

I understand that Schuyler County Mental Health will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem to be appropriated and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

I understand that my records are protected under the Federal Confidentiality Regulations (HIPAA) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I have the right to inspect and to copy the information to be disclosed. I also understand that I may revoke this consent in writing at any time expect to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below.

Specification of the date, event, or condition on which this consent expires:_____

State law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by the Illinois Mental Health and Developmental Disabilities Confidentially Act. I understand that I have the right to inspect and to copy the information to be disclosed. I will be given a copy of this authorization.

_____ _____
Signature of Client **Date** **Signature of Parent, Guardian, or Personal Rep.** **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (Power of Attorney, Healthcare Surrogate, etc.)_____

☐ Check here if patient refuses to sign authorization

_____
Signature of Staff Witness **Date**

Revised 01/2024

Schuyler County Mental Health Association Text Message Reminder Consent Form

Schuyler County Mental Health Association (SCMHA) offers text message reminders to help clients remember scheduled appointments or receive important messages. These reminders will be sent through a secure third-party service, Remind 1.

By completing and signing this form, you consent to receive appointment reminders and/or messages via text to the phone number you provide below.

Consent to Receive Text Messages

I understand and agree to the following:

- I consent to receive appointment reminders and other relevant messages via **text message** from Schuyler County Mental Health Association using the Remind 1 service.
- Text messages will be sent only for the purpose of reminders or important communication related to my care of appointments.
- Standard text messaging rates may apply depending on my mobile service plan.
- SCMHA and Remind 1 are not responsible for any charges I may incur as a result of receiving text messages.

Phone Number for Text Messages

I authorize text messages to be sent to the following mobile phone number:

Phone Number: _____

It is my responsibility to notify SCMHA **immediately** if my phone number changes. I understand that failure to update my contact information may result in missed communications.

Client Acknowledgment and Signature

By signing below, I acknowledge that I have read, understand, and agree to the terms above.

Client Name: _____

Signature: _____

Date: _____

If you wish to withdraw your consent at any time, please notify the front desk or your provider.

Thank you for helping us better serve you.