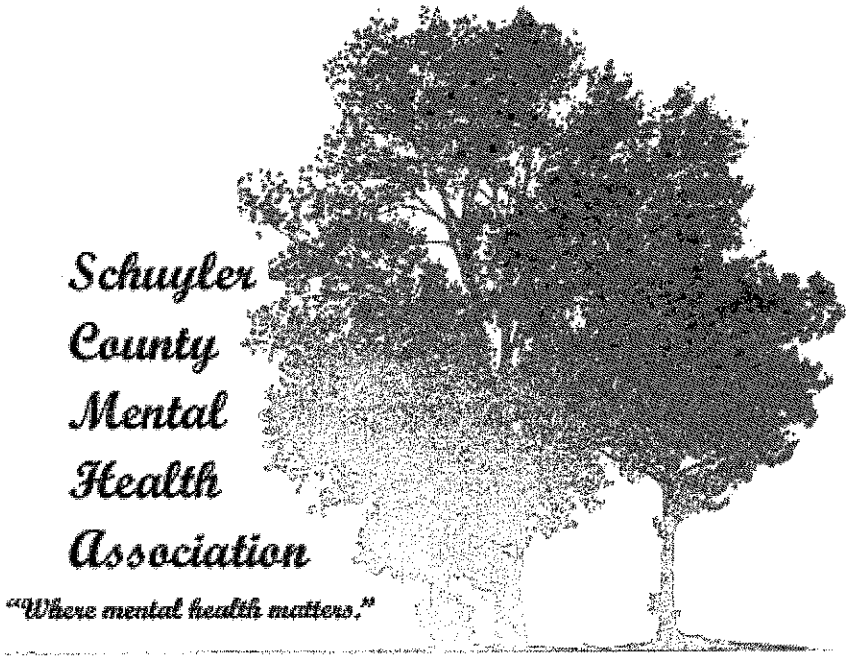

Client Review Handbook

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

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 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