Family
Counseling Service

CLIENT INFORMATION

Client's name:_____

Date of birth:_____

Email address:_____

SYMPTOM CHECKLIST

Family Counseling Service

Over the past month, I've experienced the following at least once (check all that apply):

- ☐ Feelings of guilt or worthlessness
- ☐ Worrying or anxiety
- ☐ Too much energy
- ☐ Anger or aggression toward others or property
- ☐ Afraid of school or work
- ☐ Afraid to leave the house
- ☐ Sleep problems
- ☐ Memory loss
- ☐ Trouble making decisions
- ☐ Difficulty concentrating
- ☐ Sudden mood changes
- ☐ Restlessness
- ☐ Easily distracted
- ☐ Excessive spending
- ☐ Overly tired
- ☐ Poor appetite
- ☐ Overeating
- ☐ Hearing voices
- ☐ Problems at work
- ☐ Difficulty getting along with others
- ☐ Hopelessness
- ☐ Thinking about death
- ☐ Thinking about suicide
- ☐ Self-harming behaviors
- ☐ Crying excessively
- ☐ Feeling down or "blue"
- ☐ Nightmares
- ☐ Feeling anxious or panicked
- ☐ Jealous
- ☐ Lack of confidence
- ☐ Sexual problems
- ☐ Problems with gambling
- ☐ Using alcohol or other substances

SERVICE AGREEMENT

Client Name:_____

Welcome to Family Counseling Service of Aurora. It is our privilege to offer you quality behavioral healthcare services at our agency. This document is intended to act as an agreement between you and Family Counseling Service for the services we provide.

Risks & Benefits of Behavioral Healthcare Treatment

Before you begin services, it's important to know that behavioral healthcare carries both benefits and risks. Treatment often leads to a significant reduction in feelings of distress, improved relationships and resolution of issues. Risks can include experiencing uncomfortable feelings such as sadness or anxiety during the course of treatment. If you are prescribed medication as part of your treatment, there are possible side effects to most medications. Your prescribing professional can discuss these side effects with you before you start taking new medications.

Staff Qualifications:

Family Counseling Service maintains high standards for clinical excellence. Our counselors hold degrees and are fully licensed in their area of expertise, as their level of college degree allows. Staff who are not yet clinically licensed work under the direct supervision of a licensed supervisor. We also work with psychiatrists and/or Psychiatric Advance Practice Nurses (APN's) to manage psychotropic medications.

Fees & Cancellations:

In addition to billing private insurance (e.g. Blue Cross Blue Shield), Family Counseling is funded by INC Board NFP and other public funding sources, including the Illinois Department of Human Services, Division of Mental Health (DMH) and Healthcare and Family Services (HFS). We offer a sliding fee scale to accommodate the income circumstances of our clients when necessary. If you are paying a sliding scale fee, the difference in costs will be made up by one of the funding sources listed above.

If you are unable to attend a scheduled session, please notify us at least 24 hours in advance. If you miss your appointment, you may be charged a $20 cancellation/missed appointment fee. This is simply because we have many clients who are waiting for open appointments and would like to be able to offer them your appointment if you need to cancel for any reason.

If you fail to attend 3 or more appointments and carry a balance of $60 or more, services may be suspended until the balance is paid in full or payment arrangements have been made. Questions about balances or payment arrangements can be directed to the billing department at 630-844-6246.

Most contracted services (for example, if an insurance company or state agency is paying for your services here) do not reimburse us for missed or cancelled appointments, If your services are being paid for through an outside contract and you have a late cancellation or fail to keep an appointment, you may be responsible for payment for the missed session.

Confidentiality of Your Records

As a client, you will provide us with some important and sensitive information about yourself. This information is known as Protected Health Information. Family Counseling Service will not disclose your Protected Health Information UNLESS we have your written authorization to do so, except under the following special circumstances. State and federal laws require Family Counseling Service to disclose your private information without your consent in certain circumstances, including the following:

- Child Abuse: If your counselor has reasonable cause to believe a child known to him/her in his/her professional capacity may be an abused child or a neglected child, your counselor must report this belief in accordance with the Abused and Neglected Child Reporting Act.

- Adult and Domestic Abuse: If your counselor has reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, he/she must report this belief in accordance with the Illinois Elder Abuse and Neglect Act.

- Serious Threat to Health or Safety: If your counselor believes that you present a clear, imminent risk of physical or mental injury being inflicted against yourself or another individual, he/she may make disclosures that he/she believes are necessary to protect that individual from harm in accordance with the Illinois Mental Health and Developmental Disabilities Confidentiality Act, or Public Act 098-0063 (Firearm Concealed Carry Act).

Federal law also permits us to use your protected health information for the following purposes:

- For Payment: We may use and disclose your Protected Health Information to be reimbursed for the medical services and supplies we provide to you. For example, your health plan or Health Insurance Company may ask to see parts of your medical record before they will pay us for your treatment.

- For Health Care Operations: We may use and disclose your Protected Health Information for health care management, which include internal education, administration, planning, and other various activities that improve the quality of care we provide to clients. We may disclose Protected Health Information to outside companies to support administrative functions such as data analysis, accounting or legal services, but we will only do so after they have signed an agreement stating that they will abide by our privacy policy. This information is usually aggregated, so no individual can be identified.

- For Quality Improvement: At completion of treatment, we would like to send a satisfaction survey and feedback form via email to ensure we are providing the highest quality of care and aim to improve in any area when applicable. You will be asked to provide an email address to receive this survey via email but can refuse at any time. Your contact information including your email is Protected Health Information and will not be distributed without written authorization.

CLIENT RIGHTS

As a client of Family Counseling Service, you ate entitled to the rights outlined in the Mental Health and Developmental Disabilities Confidentiality Act and Chapter 2 of the Mental Health Code Developmental Disabilities Code. Client rights and FCS responsibilities include but are not limited to, the following:

- You have a right to be provided mental health services in the least restrictive setting.
- You have the right to a safe and therapeutic environment. Agency staff will provide the necessary supports and resources to keep you, other clients and staff safe and minimize the use of restrictive behavioral management interventions. Staff will use verbal and non-verbal de-escalation strategies to maintain a safe environment. If staff determine there is imminent risk of harm, they may deem the use of manual restraint necessary until law enforcement arrives to ensure the safety of the others. For minors, the parent/guardian will be notified if a minor is involved in harassment, violence or when a restrictive intervention is used.
- You are entitled to have your rights explained to you using a language or method of communication you understand upon commencement of services.

- You may have a guardian with whom we must cooperate or you may be restricted legally through court or by probation.
- You have the right to nondiscriminatory access to services as specified in the Americans with Disabilities Act of 1990 (42 USC 12101). You have the right to have disabilities accommodated according to section 504 of the Rehabilitation Act and the Human Rights Act.
- You have the right to be free from abuse and neglect.
- You do not have to provide information regarding HIV/AIDS status or testing. If information is provided, it will not appear in your clinical record, be discussed with personnel, or be released to any other agency.
- You and/or your guardian have the right to receive a copy of the agency's grievance procedure and will not be denied service, suspended from services, or terminated from services because of filing a grievance. You have the right to present a grievance up to and including FCS's Board of Directors. You will receive a response to your grievance within 5 business days. The Board of Director's response to the grievance will constitute a final administrative decision. A record of grievances and responses will be maintained in your client file.
- If applicable, you have the right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
- You have the right to an individualized treatment plan that is based on your strengths, abilities, needs, preferences, and desired outcomes. You have a right to a copy of your plan.
- You have the right to services free from abuse, neglect, seclusion, retaliation, humiliation, corporal punishment, or exploitation, including financial exploitation.
- You have a right to privacy and no information will be disclosed about you to others without your informed written consent, except for the following: FCS has to follow state laws about special requests for information.
- We have a responsibility to warn others if you threaten to hurt them. We must report any suspected child or elder abuse or neglect. We may communicate information to others if you are at risk of harming yourself or others.
- Your confidentiality is governed by the Confidentiality Act and the Health Insurance Portability and Accountability Act of 1996 (HIPPA). If your confidentiality rights are restricted for any reason, justification for the restriction shall be documented in your clinical record. For minors, the client and the guardian shall be notified of the restriction.
- You have the right to contact the Guardianship and Advocacy Commission or Equip for Equality if you believe your rights have been violated. Our staff will assist you in contacting these groups if you so desire.
- You have the right to be free from exploitation.
- You have the right not to be denied mental health services because of age, sex, race, religious belief, ethnic origin, marital status, sexual orientation, physical or mental disability, or criminal record that is unrelated to any possible present dangerous behavior, HIV/AIDS status, or ability to pay.
- You have the right not to have services denied, suspended, reduced or terminated for exercising your rights.
- You and/or your guardian have a right to present grievances up to and including FCS's executive director. The executive director's decision on the grievance shall constitute a final administrative decision. You will be informed by our staff how your grievance will be handled. ECS shall keep a written record of your grievance.
- You have the right to give informed consent to services and treatment. Except in emergencies no services will be provided to you without your or your guardian's informed consent.
- You have the right to refuse any services that are offered to you, and to be informed of the consequences, if any, of such refusal.

- You have the right to purchase and use the services of other professionals, or private physicians, and other behavioral health services and providers, and to have FCS transmit your records to another provider at your legal request.
- You have the right to participate in any team meeting where your case is being discussed.
- The State of IL requires reporting of Tuberculosis. Individuals who have or are suspected of having TB will be reported to Public Health as required by statute.
- You have the right to inspect and copy your clinical records that are generated by FCS. You have the right to request corrections of errors or incomplete information.
- Any incidents of abuse or neglect will be reported to the Department of Public Health, IL Dept. of Human Services, or the IL State Police for investigation.

If your rights are restricted for any reason, staff must notify:

1. You and the person of your choice, if one is identified
2. Your parent or guardian if you are under 18, and your guardian if one has been appointed
3. FCS's Executive Director
4. The Guardianship and Advocacy Commission if you say you want the Commission to be contacted and all persons and agencies that you choose to know about the restriction.

Staff must document justification for rights restriction in your client record.
You have the right to contact any of the following if you have questions about your rights:

1. Guardianship and Advocacy Commission: 9511 Harrison Ave, Room F A 101, DesPlaines, IL 60116 847-294-4264
2. Equip for Equality: 20 N. Michigan Ave, Chicago, IL 60602 312-341-0022 (Voice and TDD) 800-537-2632
3. Office of the Inspector General: 32 W. Randolph St., Chicago, IL 60602 Hotline: 800-368-1463 TTY: 800-524-8794 Fax: 708-338-7410
4. IL Dept. of Human Services: 401 S. Clinton 7th Floor, Chicago, IL 60607 312-814-4951
5. IL Dept. of Public Health: 525 W. Jefferson St., Springfield, IL 62761 800-252-4343
6. IL Dept. of Healthcare and Family Services: 100 S. Grand Ave. E., Springfield, IL 62762 800-843-6154

CLIENT RESPONSIBILITIES

Family Counseling Service believes that clients have responsibility for their own health and well-being as much as this is possible. A mutually acceptable partnership between clients and service providers can be ensured if clients are aware of their following responsibilities:

- To show consideration and respect and behave in a manner which does not cause undue disruption to staff and other clients at FCS.
- To maintain confidentiality regarding information about other clients in groups or programs conducted by FCS.
- To provide complete and accurate information to FCS in order to receive the best care. Clients are encouraged to ask questions, discuss treatment and if in doubt request a second opinion.
- To keep appointments or to cancel at least 24 hours in advance if unable to attend.
- To pay account balances in a timely manner or make payment arrangements.
- To follow action plans or treatment programs which have been chosen in consultation with the service provider.
- Give accurate information about their mental health, substance use, and domestic violence issues as well as other circumstances which might impact upon the care of their children;
- Inform staff immediately if they have any concerns or problems with the service they are receiving.

By signing below, I am agreeing to receive treatment and/or intervention services at Family Counseling Service of Aurora.

I also understand and agree to the following terms:

- I have been informed of potential risks and benefits of services and wish to pursue services.
- I have read the service agreement and will abide by the fee and cancellation policy.
- I understand the confidentiality policies of Family Counseling Service.
- I understand that my counseling sessions will not be recorded or observed by a supervisor without my signed agreement, and that I have the right to request a different room if I do not want to conduct sessions that have a camera
- I have received a copy of the Client Rights and Responsibilities.
- I understand that I can revoke this consent at any time.

I consent to participate in the following services IF recommended by FCS staff:

- Behavioral health assessment
- Treatment plan development
- Individual counseling/therapy
- Group counseling/therapy
- Family counseling/therapy
- Substance abuse assessment
- Substance abuse treatment
- Case management services
- Psychiatric evaluation/medication management
- Psychiatric nursing services
- Community Support services

Client signature:_____

Date:_____

Guardian signature if client is under 12 years of age:_____

Date:_____

FCS staff certify that:

- I have explained this service agreement, including the client's rights and responsibilities, to the client and/or guardian and believe they were understood.
- I have answered any questions that were posed by the client and/or guardian.
- I have provided the client with a signed copy of this entire document.
- I have explained to process of gathering client feedback and will collect an email address with client consent

Staff signature:_____

Date:_____

Documentation of Consumer Choice to Receive DHS-Funded Services

If you are covered by a Medicaid insurance program, the Department of Human Services (DHS) may pay for some or all of the costs of your community mental health services. If DHS is to pay for these services, Family Counseling Service (FCS) must report certain personal information to the Department. If you do not want FCS to report this information, you may decline to be a recipient of DHS funding. If you do not decline, FCS will report all of the following information to the Department of Human Services:

- Your full name (first, last, and middle initial)
- Your social security number
- Your birth date
- Your gender (male, female)
- Your county of residence
- Your household income and size
- All mental health services for which the provider expects payment

To ACCEPT being considered as a DHS consumer, check both boxes:

☐ I choose to have FCS bill DHS for my services

☐ I understand FCS will report the information above to the Illinois Department of Human Services

Client signature:
Date:

To DECLINE being considered as a DHS consumer, check both boxes:

☐ I choose to NOT have FCS bill DHS for my services

☐ I understand FCS will NOT report the information above to the Illinois Department of Human Services

Client signature:_____

Date:_____

Staff signature:_____

Date:_____

Explanation by the provider why consumer choice was not documented, if necessary:

ELECTRONIC COMMUNICATION AGREEMENT

Family Counseling Service

Client name:_____

It is the policy of FCS to communicate confidential and Protected Health Information (PHI) via secure methods; typically in person, by telephone, or via U.S. mail. By signing this consent, you acknowledge that receiving electronic communication (for example, email or text) may put your protected health information at risk. By signing this agreement you give consent for electronic communication about upcoming appointments, answers to your electronically posed questions that may include clinical content, and/or financial information via text and/or email. You also acknowledge that not all email and/or text platforms are encrypted or secure, and grant permission for FCS staff to communicate with you using these methods.

Client signature:_____

Date:_____

FCS offers telehealth (video) services for therapy/counseling and for psychiatric appointments. If you elect to use telehealth services, your counselor, medication provider, etc. at FCS will be in their office at FCS using a camera and microphone with their computer. You will have the option of using any computer, tablet, or phone that has a camera and internet access. By doing so, you will be able to participate in regular behavioral healthcare services from another location, such as your home. FCS uses a HIPAA-compliant telehealth platform that meets recommended standards to protect the privacy and security of the video appointments.

There may be some risks and benefits to using telehealth services:

- The *benefits* of a telehealth appointment can be: Reducing the waiting time to see a clinician; keeping appointments that would otherwise be canceled due to travel difficulties or illness; decreasing the amount of time required to fully participate in behavioral healthcare. You may not achieve all these benefits and they are not guaranteed or assured.

- The *risks* of a telehealth appointment can be: telehealth appointments may not be exactly the same, or may not be as complete as a face-to- face service; or there could be some technical problems that affect the video visit.

You will always be given a choice about whether to receive telehealth or in-person services. If you agree to sometimes use telehealth services, you can stop participating in telehealth services at any time. The dissemination of any personally identifiable images or information from the telehealth appointments will not occur without your written consent.

Client signature:_____

Date:_____

Your email address:_____

You cell phone number:_____

Name of cell phone provider (e.g. Verizon, etc.): _____

INSURANCE AND FEES

Client name:_____

Most 3rd party payers (for example, insurance companies), require FCS to release certain information about diagnosis, type/place of service rendered, dates of service, and possibly other information. Some payers require a treatment plan and/or periodic review of services being provided.

Do you expect an insurance company to pay for your services? ☐ Yes ☐ No

If yes, please provide the following information:

Primary Insurance Company: _____

Address:_____

Ins. Phone Number (back of card):_____

Group/Policy Number(s): _____

Name of Insured Person's Employer: _____

Insured's Date of Birth: _____

Insured's SSN: _____

If your insurance company refuses payment, FCS will resubmit the claims for payment. If the insurance company continues to refuse payment for any reason, **you will be responsible for payment for professional services**. If you have trouble affording the balance owed, our billing department will work with you to make payment arrangements.

- I authorize payment of my medical benefits (if any) to Family Counseling Service of Aurora
- I agree to pay the estimated copayment per session
- I acknowledge full responsibility for payment of all professional fees, including those not covered by insurance
- I authorize the release of any information pertinent to payment for my services to the appropriate payer

Client signature:_____

Date:_____

Parent/guardian signature, if applicable:_____

Date:_____

If you have no insurance, or your insurance does not cover the services you will be receiving from FCS, a sliding fee scale is available. Below is a list of fees for services utilizing the sliding fee scale.

Annual Income:	Grant-funded programs	$0 - $34,999	$35,000 - $44,999	$45,000 - $54,999	$55,000 - $64,999	$65,000 - $74,999	$75,000 - $84,999	$85,000 - $94,999	$95,000 - $104,999	$105,000 or more
Behavioral Healthcare Counseling	n/a	35	45	55	65	75	85	95	100	120
Behavioral Healthcare Groups	n/a	25	25	25	25	25	25	25	25	25
Older Adult Services	0	0	0	0	0	0	0	0	0	0
Violence Intervention Services	n/a	25	40	40	55	55	55	55	55	55
Substance Abuse Evaluation	n/a	35	35	35	35	35	35	35	35	35
Substance Abuse Treatment (Group)	n/a	25	25	25	25	25	25	25	25	25
Substance Abuse Treatment (Individual)	n/a	35	35	35	35	35	35	35	35	35
Substance Abuse Treatment - estimated program cost	n/a	400	400	400	400	400	400	400	400	400