In-Home Counseling
800 N. Main St, Suite 210 Antioch, IL 60002
Office (847) 903-5604 Fax (224) 788-5112

CLIENT'S INFORMED CONSENT

- I have chosen to receive treatment services from In-Home Counseling. My choice has been voluntary and I understand that I may terminate therapy at any time.
- I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.
- I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.
- I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.
- I understand that the state and local laws require that my therapist report all cases in which there exists a danger to self or others.
- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- I understand that I may be contacted by my insurance provider to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.
- I have read and had explained to me the basic rights of individuals seeking psychotherapy. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that my therapist and insurance provider may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

_____

Signature of Client Date

_____

Signature of Witness Date

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NOTICE OF PRIVACY PRACTICES

In-Home Counseling (IHC)

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.

IHC is required, by law, to maintain the privacy and confidentiality of your Protected Health Information (PHI) and to provide its patients with notice of its legal duties and privacy practices with respect to your PHI. Disclosure of Your Health Care Information:

Treatment
We may disclose your PHI to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with IHC.

Payment
We may disclose your PHI to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to IHC for health care services rendered. The billing statement contains medical information, including diagnosis, date of service rendered, and codes which describe the health care services received.

Emergencies
We may disclose your PHI to a family member, or another person responsible for your care in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: reporting elder abuse or neglect and/or domestic violence.

Research
We may disclose your health information to researchers conducting research that has been approved by the State of Illinois Department of Human Services.

Change in Practice
In the event that IHC is sold or merged with another organization, your health information/record will become the property of the new owner. You will be notified in writing of this change.

Death of Therapist
In the event of the death of your therapist, your health information/record will be transferred to a new therapist. You will be notified in writing of this change.

Your Health Information Rights
Each person over the age of 18 has the right to request restrictions on certain uses and disclosures of their health information. Please be advised, however, that IHC is not required to agree to the restrictions requested.

You have the right to request that your health information be received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery.

You have the right to inspect and copy your health information. You have the right to request that IHC amend your PHI. However, IHC is not required to agree to amend your protected health information. If your request to amend your health information is denied, you will be provided with an explanation of our denial reason(s) and with information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your PHI made by IHC. Please send your request for information in writing to: In-Home Counseling, 800 N. Main St. Suite 210, Antioch, IL 60002. We may charge you a fee to cover the cost of copying, mailing and other supplies to provide you with requested information. We may deny a person's request to review and copy information in certain limited circumstances. If IHC denies a client's request for information, the client may be entitled to a review of that denial.

If you feel that your PHI is incorrect or incomplete, you have the right to request that we amend it. A request to amend your PHI must be submitted in writing to: In-Home Counseling, 800 N. Main St. Suite 210, Antioch, IL 60002. A client has the right to request that we place restrictions on disclosure of their PHI for treatment, payment and health care operations. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. Request to place restrictions on disclosure of your PHI must be submitted in writing to: In-Home Counseling, 800 N. Main St. Suite 210, Antioch, IL 60002.

Confidentiality Communication
The client has a right to request that we communicate with them in confidence about their PHI by alternative means or to an alternative location. For example: The client may ask that we contact them only at work or by mail. The client must specify how and where they wish to be contacted. We will accommodate all reasonable requests. We require you to send us a written request to: In-Home Counseling, 800 N. Main St. Suite 210, Antioch, IL 60002.

Others Acting on a Client's Behalf
These rights may also be exercised by someone who has the legal right to act on the client's behalf.

Changes to this Notice of Privacy Practices
IHC reserves the right to amend this Notice of Privacy Practices at any time, and will make any new provisions effective for all information that it maintains. Until such amendment is made, IHC is required by law to comply with this Notice. IHC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions, objections, or changes about any part of this notice or if you want more information about your privacy rights, please contact IHC's privacy officer at (847) 903-5604.

Copy of this Notice
The client is entitled to receive a printed (paper) copy of this notice at any time. Please contact us using the information listed above either by phone or in writing.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE
In-Home Counseling (IHC)

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of IHC's "NOTICE OF PRIVACY PRACTICES".

As required by the Privacy Regulations, _____
from IHC has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that IHC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all Protected Health Information (PHI) that it maintains.

On separate form(s), I am noting to whom I wish my PHI to be communicated.

I agree that all my PHI may be communicated by letter, fax, or telephone and any or all of these forms of communication.

I understand that IHC is not required to honor any changes to the "NOTICE OF PRIVACY PRACTICES".

_____ _____
Signature Date

_____ _____
Witness Date

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PATIENT_____

DOB_____

I understand that the State of Illinois requires my primary care physician to be notified that I am seeking assistance from In-Home Counseling. I further understand that I may choose to have my therapist NOT notify my primary care physician.

My primary care physician: _____

_____

I choose to have _____notify my physician:

Yes _____ No _____

_____
Signature of Client Date

_____
Witness Date

Notification to Primary Care Physician of Patient Receiving Mental Health Services

Pursuant to Illinois law requiring that Licensed Clinical Social Workers inform their patients' primary care physician that a patient is seeking or receiving mental health services, you are hereby notified

that _____ is seeking or receiving such services from me. The patient has signed an Authorization for Release of Information, a copy of which I am enclosing for your records. I look forward to the opportunity to confer with you about this patient as the occasion or need arises.

_____
Therapist Date

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Authorization for Release of Health Care Information

I, _____
Name of Client Date of Birth

_____
Address of Client Authorizing Release

_____
City, State, Zip of Client

_____
Person or Facility Name Address City State Zip

Phone #_____Fax # _____

Authorize Release of Information TO and FROM In-Home Counseling:
[ ] All Information (no limitations)
[ ] Medical History, Records, Labs, or Treatment
[ ] Psychiatric or Psychological Testing, Evaluation or Treatment
[ ] Substance Abuse Evaluation or Treatment
[ ] Discharge Planning
[ ] Attendance and Participation in Counseling Sessions

This information is to be used only for the purpose of evaluation and/or treatment, and to coordinate care.

My signature, giving consent, expires _____. The information released will be limited to the above identified requested information. The above requested information shall be released only to the requesting person or facility and the information may not be disclosed any further for any reason. I understand I have the right to inspect and copy the information released. It is further understood that I have been advised that I have the right to revoke this consent at any time. I understand that my refusal to consent to the release of information specified, will prevent disclosure of such information to the person named herein.

CLIENT: _____DATE: _____

WITNESS: _____DATE:_____

In sending this consent for Release of Information, I understand there is no charge for this information. If there is any charge for gathering this information and forwarding it to In-Home Counseling, please cancel this request.