# IAG Behavioral Health Center Policy

Welcome to The IAG Behavioral Health Center (BHC).

This document contains important information about our professional services and policies. Please read it carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between you ("the client") and the IAG BHC ("the clinic").

**TREATMENT:** The clinic provides confidential counseling, psychotherapy, group therapy, family therapy, case management and medication management either on-site or virtually. It involves a relationship between a client and a trained professional who has the desire and willingness to help accomplish the client's individual goals. Please note: clinic staff does not address medical emergencies virtually. If the client is experiencing a medical emergency, call 911 or go to your nearest emergency room.

**CONFIDENTIALITY:** Communication between a client and therapist is confidential. This means that the therapist will not discuss the client's case orally or in writing without explicit consent. Exceptions to this rule may include, but are not limited to the following:

- Clients under the age of 18, when parents or legal guardian(s) may have access to your records or may authorize their release to other parties.
- If you are reasonably suspected to be in imminent danger of harming yourself or others.
- If you disclose abuse or neglect of children, the elderly, or disabled persons.
- If you disclose sexual misconduct by a therapist.
- To qualified personnel for program audits or evaluations.
- Upon the issuance of a court order or lawfully issued subpoena; otherwise legally required.

**CONSULTATION:** When appropriate, therapists may consult with a peer/supervisor for education and support services. They may also consult with a psychiatrist or psychiatric nurse practitioner (often contracted via a third-party agency) regarding any medication, on behalf of the client or to gain insight in relation to medication management.

**COUNSELING RECORDS:** Counseling records are stored in locked files and/or electronically on a secure server (for at least seven years) that is only accessible by clinic staff. Upon request, the client may review their counseling records with the therapist or another appropriate member of the clinic staff. Records can be released to an outside provider with an appropriate release of information request.

**COUNSELING DECISIONS:** Frequency of sessions, number of sessions, goals, type of counseling and any alternative counseling methods will be discussed and negotiated between the client and the therapist. Progress and goals of counseling will be regularly discussed between client and therapist. If the client has questions about recommendations or the approach used by therapist, this should be discussed with the therapist during the session.

**ACCESS TO SERVICES:** Clinic hours are Monday through Friday from 9 am to 5 pm. Clinic hours may vary on holidays. Services are offered onsite (30 Phelps Ave, Romeoville, IL 60446) or virtually.

A client in crisis can come to the office or request virtual treatment at any time during office hours and be worked into a schedule for a brief evaluation. If it is after office hours and the client is in imminent crisis, please call 911 or visit your local emergency room.

**ELECTRONIC COMMUNICATION:** The use of electronic communication (e.g., email, texts, faxes) with clinic staff is discouraged. Confidentiality cannot be assured via electronic communication. When necessary, electronic communication may be used for scheduling appointments or general questions but should not be used for counseling purposes or major forms of communication. The best form of communication for all counseling needs is via telephone. Please contact the clinic (630-755-0053) or the therapist directly if your message is time critical.

**SCHEDULING AND ATTENDANCE:** If the client is not able to attend a scheduled session, the client should notify the clinic or therapist directly. All cancellations or rescheduling requests must be received by the clinic 24 hours prior to your scheduled appointment. Any missed appointments or cancellations received less than 24 hours from your scheduled appointment may be subject to full payment for services. Charges for missed appointments cannot be billed to insurance and will be the client's financial responsibility. If a client "no calls/no shows" three scheduled sessions, they will be subject to discharge from the clinic. The client may choose to stop therapy at any time, and the client agrees to inform the therapist of the decision prior to the last visit. If the therapist believes that the client can receive more effective treatment elsewhere, the client will be given referrals. The client understands that they may not attend a session if they are under the influence of alcohol or drugs, or if in possession of a dangerous weapon.

**PAYMENT & INSURANCE REIMBURSEMENT:** The client is fully responsible for the payment of all fees for services provided regardless of any insurance coverage. Co-pays and non-covered services are payable at time of service, unless other arrangements have been made. The clinic accepts checks or credit cards as forms of payment. All sessions are 45 - 60-minutes in length. The fee for an initial intake session is $160.00. Follow up session fees for individuals ($100-$150), couples or families $135. The client understands that the clinic will either file the claim on their behalf or will provide the client with the necessary information so that they can file the claim. If insurance is billed on the client's behalf, the client authorizes payment of mental health benefits to the clinic.

## 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.

### YOUR RIGHTS

When it comes to your health information, you have certain rights.

| | |
|---|---|
| Get an electronic or paper copy of your health record | • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.<br>• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| Ask us to correct your health record | • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.<br>• We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| Request confidential communications | • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>• We will say "yes" to all reasonable requests. |
| Ask us to limit what we use or share | • You can ask us not to use or share certain health information for treatment, payment, or our operations.<br>  ○ We are not required to agree to your request, and we may say "no" if it would affect your care.<br>• you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.<br>  ○ We will say "yes" unless a law requires us to share that information. |
| Get a list of those with who we've shared information | • You can ask for a list (accounting) of the times we've shared your health information for seven years prior to the date you ask, who we shared it with, and why.<br>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| Get a copy of this privacy notice | • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |

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|---|---|
| Choose someone to act for you | • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br>• We will make sure the person has this authority and can act for you before we take any action. |
| File a complaint if you feel your rights are violated | • You can complain if you feel we have violated your rights by contacting using the information at the bottom of this notice.<br>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting www.hhs.gov/ocr/privacy/hipaa/ complaints/.<br>• We will not retaliate against you for filing a complaint. |

## YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

| | |
|---|---|
| In these cases, you have both the right and choice to tell us to: | • Share information with your family, close friends, or others involved in your care.<br>• Share information in a disaster relief situation. |
| In these cases we never share your information unless you give us written permission: | • Marketing purposes<br>• Sale of your information<br>• Most sharing of psychotherapy notes<br>• Substance abuse treatment records |
| In the case of fundraising | • We may contact you for fundraising efforts, but you can tell us not to contact you again. |

## OUR USES AND DISCLOSURES

How we typically use or share your health information.

| | |
|---|---|
| Treat you | • We can use your health information and share it with other professionals who are treating you. |
| Run our organization | • We can use and share your health information to run our practice, improve your care, and contact you when necessary. |
| Bill for your services | • We can use and share your health information to bill and get payment from health plans or other entities. |
| Do research | • We can use or share your information for health research. |
| Comply with the law | • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. |

| | |
|---|---|
| Address workers' compensation, law enforcement, and other government requests | • We can use or share health information about you:<br>○ For workers' compensation claims<br>○ For law enforcement purposes or with a law enforcement official<br>○ With health oversight agencies for activities authorized by law<br>○ For special government functions such as military, national security, and presidential protective services |
| Respond to lawsuits and legal actions | • We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

**OUR RESPONSIBILITY**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**CHANGES TO THE TERMS OF THIS NOTICE**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice of Privacy Practices applies to IAG Behavioral Health Center and Individual Advocacy Group Inc which operates all IAG affiliates.

*If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.*


| | |
|---|---|
| Name of Contact Person: | Danielle Cura, LCSW, ACM-SW |
| Telephone: | 630-746-0937 |
| Fax: | 630-755-0054 |
| Email: | iagbhc@iaginc.org |
| Address: | 1289 Windham Pkwy, Romeoville IL 60446 |

Updated 10/24/2023

**Informed Consent for Treatment**

I, _____ (client or guardian, if necessary), hereby voluntarily consent for _____ (client), date of birth: _____, to attend the IAG Behavioral Health Center (BHC) at 30 Phelps Ave, Romeoville, IL 60446 for an intake screening and assessment to determine if the clinic can meet the client's needs, effective as of _____ (today's date). Services at the IAG Behavioral Health Center may include individualized treatment planning, psychotherapy, family or group therapy, case management, medication management or training, and psychiatric evaluations.

I understand that the potential benefits of receiving services may include obtaining a professional opinion other than my therapist. I understand that the staff of the IAG Behavioral Health Center may consult and collaborate on cases where therapeutically appropriate.

I understand and agree that disclosures and communications are considered privileged and confidential, with exceptions in cases explained in the policy. Disclosures will be communicated to the client in a timely manner.

I authorize IAG BHC to release any personal health information pertaining to diagnosis and treatment to any insurance company or third party who undertakes responsibility for IAG BHC's professional service fees. I hereby authorize full payment of the insured portion of the charges to be paid directly to IAG BHC and understand that any portion of the fee not covered by the insurance is the responsibility of the client.

I understand that I may withdraw my consent at any time. Termination of consent may result in a cancellation of services.

My signature below indicates that I have read, understand, and agree to the statements made in the "IAG Behavioral Health Center Policy," "Notice of Privacy Policy," and "Informed Consent for Treatment" forms, and would like to proceed with services.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Client / Guardian Signature | Print Name | Relationship to client | Date |
| _____ | _____ | _____ | |
| Therapist Signature | Print Name | Date | |

**Authorization to Release Information- Part 1**

Client Name:_____ DOB:_____

Address:_____ Phone:_____

**Purpose of Release:**
This release is to authorize IAG Behavioral Health Center and an outside provider to release information to each other in order to provide quality services and continuity of care for the client named above.

| **I hereby authorize:** | **To:** | |
|---|---|---|
| IAG Behavioral Health Center<br>30 Phelps Ave.<br>Romeoville, IL 60446<br>Phone: 630-755-0053<br>Fax:630-755-0054 | ☐ Release Information to:<br>☐ Obtain Information from:<br>☐ Exchange information with: | **Name:**<br>_____<br>**Address:**<br>_____<br>_____<br>**Phone**:<br>_____ |

**Information to be released:**

- ☐ Physician orders
- ☐ Medication administration records
- ☐ Lab results
- ☐ Treatment records
- ☐ Social history
- ☐ Psychological evaluations
- ☐ Psychotherapy notes
- ☐ Insurance cards/information
- ☐ Other _____

**Authorization:**
This voluntary information release is authorized on _____ (today's date) and is valid for one year, unless otherwise revoked.

I understand that failure to sign this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

| _____ | _____ | _____ | _____ | _____ |
|---|---|---|---|---|
| Client / Guardian Signature | Print Name | Relationship to client | Date | Time |

## Authorization to Release Information- Part 2 Revocation

Client Name:_____ DOB:_____

Address:_____ Phone:_____

**Right to Revoke**

If you no longer want IAG Behavioral Health Center to share your health information, please sign this revocation and return it to:

IAG Behavioral Health Center
30 Phelps Ave.
Romeoville, IL 60446
Phone: 630-755-0053
Fax:630-755-0054

I understand that:

- In the event my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health information. Revocation will only apply to future transactions.
- Once information has been shared with another entity, IAG Behavioral Health Center cannot guarantee that the entity in question will not further share your information
- I understand that I do not need to give any further permission for the information shared with the provider in part 1.

☐ I no longer want IAG Behavioral Health Center to share my health information with the person or entity indicated above (in part 1).

| _____ | _____ | _____ | _____ | _____ |
|---|---|---|---|---|
| Client / Guardian Signature | Print Name | Relationship to client | Date | Time |

## Consent for Teletherapy

I, _____, (client or guardian) hereby consent for _____ (client) to participate in teletherapy with IAG Behavioral Health Center, as part of my psychotherapy. I understand that teletherapy is the practice of delivering clinical mental health care services via technology assisted media or other electronic means between a practitioner and a client. I understand the following with respect to teletherapy:

1. I understand that teletherapy services are available only to those clients who are residents of Illinois, as therapists are only permitted to provide clinical services to those living in the state where the therapist is licensed.
2. I understand that I have the right to withdraw consent at any time without affecting my right to available future care.
3. I understand that there are risks, benefits, and consequences associated with teletherapy, including but not limited to, disruption of transmission by technology failures and/or limited ability to respond to emergencies.
4. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
5. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) in traditional psychotherapy also apply to teletherapy services.
6. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that teletherapy services are not appropriate and a higher level of care is required.
7. I understand that during a teletherapy session, we could encounter technical difficulties resulting in service interruptions. If this occurs, we will end and restart the session. If we are unable to reconnect within ten minutes, we will communicate about rescheduling the session.
8. I understand that IAG Behavioral Health Center needs to know my location and I agree to inform my therapist of the address where I am at the beginning of each session.
9. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in the case of an emergency.

   **Emergency Contact:**

   First and Last Name:_____ Relationship:_____

   Address:_____ Phone:_____

   I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all my questions have been answered to my satisfaction.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Client / Guardian Signature | Print Name | Relationship to client | Date |

| IAG Behavioral Health Center Intake Form | | | |
|---|---|---|---|
| **Client Information** | | **Date:** | |
| Name: | | DOB: | |
| Address: | | SSN: | |
| Email: | | Phone: | |
| Marital Status: ☐Married ☐Divorced ☐Separated ☐ Domestic Partnership ☐Never Married ☐Widowed | | Gender: | |
| Advance Directives: ☐ YES ☐NO | | *If yes, please submit a copy* | |
| **Person completing this form (*if not the client*)** | | | |
| Name: | | Relationship to client: | |
| Phone: | | Email: | |
| Address: | | | |
| **Primary Insurance** | | | |
| Carrier: | | Subscriber ID: | |
| Subscriber Name: | | Group Number (if Applicable): | |
| **Complaints** | | | |
| What is your primary complaint? | | | |
| How long have you suffered from this issue(s)? | | | |
| Have you suffered from this issue(s) in the past? | | ☐ YES ☐NO | |
| Have you ever received treatment for this issue(s)? | | ☐ YES ☐NO | |
| *Type(s) of past treatment:* | | | |
| Have you ever had thoughts of harming yourself? | | ☐ YES ☐NO | |
| Have you ever actively harmed yourself?<br>*If yes, when was the last time you harmed yourself?* | | ☐ YES ☐NO<br>*Approximate Date:* | |
| Have you ever had thoughts of suicide?<br>*If yes, when was the last time you thought of suicide?* | | ☐ YES ☐NO<br>*Approximate Date:* | |
| Have you ever attempted suicide?<br>*If yes, when was the last time you attempted suicide?* | | ☐ YES ☐NO<br>*Approximate Date:* | |
| Have you ever required psychiatric hospitalization?<br>*If yes, when was your most recent psychiatric hospitalization?* | | ☐ YES ☐NO<br>*Approximate Date:* | |
| **Current Symptoms (check all that apply)** | | | |
| ☐ Anxiety | ☐ Fatigue | ☐ Hallucinations | ☐ Risky Behavior |
| ☐ Depression | ☐ Panic Attacks | ☐ Avoidance | ☐ Libido Changes |
| ☐ Loss of Interest | ☐ Impulsivity | ☐ Irritability | ☐ Obsessions |
| ☐ Sleep Changes | ☐ Mood Swings | ☐ Racing Thoughts | ☐ Compulsions |
| ☐ Appetite Changes | ☐ Suicidal Ideation | ☐ Anger/Rage | ☐ Memory Lapses |
| ☐ Too much energy | ☐ Self-Injury | ☐ Suspiciousness | ☐ Grief |
| ☐ Self-Hatred | ☐ Trauma Symptoms | ☐ Attention Problems | ☐ Agoraphobia |
| *Please use the space below to describe any other symptoms or issue you are having:* | | | |

| Medical History | |
|---|---|
| Current Medical Conditions: | |
| Current Medications: | |
| Allergies: | |
| PCP: | Phone: |

| Family History | |
|---|---|
| Is there a history of mental illness in your family?<br>*If yes, what type of mental illness?* | ☐ YES ☐NO ☐ Unknown<br>*Which family member(s)?* |
| Is there a history of medical problems in your family?<br>*If yes, what type of medical problems?* | ☐ YES ☐NO ☐ Unknown<br>*Which family member(s)?* |
| Have you lost any biological family members to death?<br>*If yes, which relative?* | ☐ YES ☐NO<br>*Approximate Date of Death:* |
| Have you lost any non-biological family members (i.e. step-sibling) to death?<br>*If yes, which non-biological relative?* | ☐ YES ☐NO<br>*Approximate Date of Death:* |
| Were you adopted? ☐ YES ☐NO | *If yes, at what age?* |
| How is your relationship with your mother? | |
| How is your relationship with your father? | |
| Did your parents ever divorce? ☐ YES ☐NO | *If yes, how old were you?* |
| Did your parents remarry? ☐ YES ☐NO | *If yes, how old were you?* |

Have you and/or your family endured any of the following?

| | | | |
|---|---|---|---|
| ☐ Natural Disaster<br>☐ Self<br>☐ Family Member | ☐ Witness to Crime<br>☐ Self<br>☐ Family Member | ☐ Child Abuse<br>☐ Self<br>☐ Family Member | ☐ Elder Neglect<br>☐ Self<br>☐ Family Member |
| ☐ War<br>☐ Self<br>☐ Family Member | ☐ Victim of Crime<br>☐ Self<br>☐ Family Member | ☐ Child Neglect<br>☐ Self<br>☐ Family Member | ☐ Witness to Death<br>☐ Self<br>☐ Family Member |
| ☐ Mass Shooting<br>☐ Self<br>☐ Family Member | ☐ Domestic Violence<br>☐ Self<br>☐ Family Member | ☐ Elder Abuse<br>☐ Self<br>☐ Family Member | ☐ Refugee Status<br>☐ Self<br>☐ Family Member |

*Please use the space below to describe any other traumatic events faced by you and/or your family:*

| Early Development |
|---|
| Did you have any medical issues at birth? |
| Did you have any trouble with developmental milestones? ☐ YES ☐ NO<br>*If yes, describe troubles with developmental milestones:* |
| Where did you grow up? |
| Did you move often? |
| Did you have a parent or family member in the armed forces? |
| Describe any neglect you suffered, and by whom: |
| Describe any abuse you suffered, and by whom: |
| *Use the space below to describe any other issues from early childhood/development:* |

| Present Situation | |
|---|---|
| Work: ☐ Full-time ☐ Part-time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired | |
| Are you married? | *If yes, date of marriage:* |
| Are you divorced? | *If yes, date of divorce:* |
| Prior marriages? | ☐ YES ☐ NO |
| Are you sexually active? | ☐ YES ☐ NO |
| (Optional): What is your sexual orientation? | |
| Do you have children? ☐ YES ☐ NO | *If yes, list ages:* |
| | *If yes, how is your relationship with your children?* |
| List anyone else who lives with you: | |
| Are you a member of a religious/spiritual group? | ☐ YES ☐ NO |
| Have you ever been arrested? | ☐ YES ☐ NO<br>*If yes, why?* |

| Have you tried any of the following (check all that apply) | | | |
|---|---|---|---|
| ☐ Alcohol | ☐ Methamphetamine | ☐ Cocaine | ☐ Hallucinogens |
| ☐ Heroin | ☐ Tobacco | ☐ Marijuana | ☐ Stimulants |
| ☐ Methadone | ☐ Ecstasy | ☐ Tranquilizers | ☐ Opioids |
| If yes, list frequency & approximate date ranges of use:<br><br>If you have used other substances not listed above, describe: | | | |

| Anything else you want your therapist to know |
|---|
| Please use the space below to describe any additional information that may be useful to address in therapy, or that you feel is important and your therapist should know about you: |
| |