IROQUOIS MENTAL HEALTH CENTER

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Iroquois Mental Health Center (the agency) and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs, which encompasses but not limited to, comprehensive assessment, individual therapy, martial counseling, family therapy, group therapy, child/adolescent therapy, crisis intervention, case management services, psychiatric evaluation and psychiatric treatment, psychological testing and psychological treatment.

I agree to participate in a comprehensive assessment as part of the initial phase of treatment, and I agree to provide to the best of my knowledge, accurate and complete information about past medical issues, medication, hospitalizations and other matters relating to my health and well being.

I understand that I can decide to not participate in treatment provided by the Iroquois Mental Health Center by not signing the Treatment Plan which will be developed with my therapist following the Assessment phase of treatment.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Agency. I authorize the agency to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Agency may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE/ COLLECTION FEE. I authorize payment to be made directly to the Agency for insurance benefits payable to me. I understand that I am financially responsible to the Agency for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees.

PRIVACY POLICY. I acknowledge having received the Agency's "Notice of Privacy Policies". My rights including the right to see and copy my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Agency has already made disclosures with my prior consent.

Client's Initials (12 and older) _____ Date_____

Parent or Guardian Initials (if applicable)_____ Date_____

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO PARTICIPATE IN TREATMENT AS OUTLINED.

I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS WHICH HAVE BEEN ANSWERED TO MY SATISFACTION

Print Client Name Date of Birth	Print Parent or Guardian Name (if applicable)
Client Signature Date of Signature	Parent or Guardian Name date (A copy of the guardianship "Letters of Office" from the court or custodial agreement is required.)
Witness Signature Date of Signature	

The rights have been explained to the client. To the best of my knowledge the client understands these rights.

Staff Signature Date

IROQUOIS MENTAL HEALTH CENTER
CLIENT ORIENTATION CHECKLIST

The following has been explained to me:

_____ Consent for treatment
_____ Identification of the person responsible for service coordination
_____ Nature and purpose of treatment
_____ Possible consequences, complications and/or risks to treatment
_____ Provision to individual of their rights as clients
_____ Provision to individual of the IMHC's grievance procedure
_____ Explanation regarding the processes of assessment, treatment planning, treatment, transitional and discharge planning referrals, and follow-up.
_____ Explanation of IMHC's comprehensive services and activities
_____ Hours of operation
_____Access to after-hour services
_____ Code of ethics followed by all staff.
_____ Confidentiality policy: staff/clients
_____ Explanation of financial obligations, fees for services, and other Financial arrangements appropriate
_____ Exclusion of restraint or seclusion practices
_____ Prohibition of smoking anywhere in the main building or annex.
_____ Explanation of policy on using or bringing illicit or licit drugs onto the premises
_____ Explanation of policy on coming to services under the influence
_____ Explanation of policy regarding weapons brought on to the premises
_____ Explanation of expectations regarding keeping scheduled appointments and consequences of not doing so regarding further scheduling with therapist and/or psychiatrist
_____ Explanation of policy regarding review of file materials or gaining copies from file
_____ Explanation of input regarding satisfaction with services
_____ Explanation of exclusionary criteria
_____ Explanation of procedures to be re-admitted into the program
_____ If ordered into treatment by court, you are expected to appear at court when ordered; any violation must be reported to court which could lead to dismissal and punishment as court sees fit
_____Tour of premises, including emergency exits, fire suppression equipment, and First aid kits
_____ Identification of therapeutic interventions, including: sanctions, interventions, Incentives, and administrative discharge criteria
_____ Notification of late cancellation/fail policy

I have been given a copy of:
_____ A statement of my rights as a client (Confidentiality)
_____ Grievance procedure/Violation of Client Rights and they have been explained to me in a language that I understand

I understand that this Center operates under a Code of Ethics for Professional Behavior and that a copy of this document is available to me if I request one.

I give my permission to this Center to contact me to participate in a "Follow-up Survey".
_____ Yes
_____ No

I understand the person responsible for coordination services for me is:

_____, whose credentials have been explained to me.

I am interested in registering to vote _____ Yes _____ No

THE ABOVE INFORMATION HAS BEEN EXPLAINED TO ME AND I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS WHICH HAVE BEEN ANSWERED TO MY SATISFACTION.

_____		_____	
Print Client Name	**date of birth**	**Print Parent or Guardian Name - if applies**	
_____		_____	
Signature of Client	**date of signature**	**Signature of Parent or Guardian**	**date**
_____			
Signature of Witness	**date of signature**		

IROQUOIS MENTAL HEALTH CENTER CLIENT RIGHTS

You Have the Right:

1. To be free of discrimination or prejudice in receiving treatment regardless of age, gender, race, religion, sexual orientation, national origin, physical situation, psychological characteristics or religious and spiritual beliefs.

2. To have services that are responsive to your age, gender, social supports, cultural orientation, psychological characteristics, sexual orientation, physical situation and spiritual beliefs.

3. To receive treatment and services regardless of the source(s) of financial support.

4. To individualized treatment.

5. To be involved in the assessment and development of the Treatment Plan and to discuss any aspect of your treatment with your counselor.

6. To treatment in the least restrictive environment.

7. To have all information about you and your treatment to be held in strict confidence in accord with the state, federal and agency regulations and laws on confidentiality. You have a right to be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code. [405 ILCSS]. The rights on confidentiality is governed by the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110] and by the Health Insurance Portability and Accountability Act of 1996, HIPPA (45 CFR 160 and 164). Agency Staff are mandated reporters for DCFS & Elder Abuse.

8. To be informed about the nature of your care, procedures and treatment received in understandable terms.

9. To be informed about all possible consequences and benefits of all medications and treatment procedures used, and to give a written consent for treatment and a copy of the treatment plan.

10. To examine and receive an explanation of your bill, regardless of source of payment.

11. To stop treatment whenever you wish and to be informed of the consequences resulting from a refusal of treatment.

12. To be given help in meeting your continuing emotional and physical requirements upon case closing.

13. If you are 14 to 17 years of age, you are entitled to active participation in treatment and have up to five counseling sessions without parent or guardian knowledge or consent. Consent of treatment becomes necessary by law after five sessions.

14. To treatment free from any forms of abuse or retaliation, including psychological abuse, sexual abuse, punishment, neglect, harassment, humiliation, threats, fiduciary abuse and exploitation.

15. To receive considerate and respectful care.

16. To not be "abandoned" in treatment.

17. To not be denied, suspended, or terminated from services or have services reduced from exercising any of your rights.

18. To confidentiality of HIV antibody and/or AIDS status.

19. To know the name of the person coordinating your care.

20. To have the opportunity to evaluate the agency's service.

21. You have the right to receive Crisis Services.

22. You have a right to request a copy of the agency Code of Ethics and Professional Behavior.

23. You have the right to file a grievance up to the level of the Executive Director.

24. You have the right to informed consent.

25. You have a right to access your own lawyers or have referral information to access legal entities.

26. You have a right to go to advocacy/self help groups.

27. You have a right to refuse services from the person or service delivery team you get assigned and a right to request a specific clinician, if available, and referral given if preferred or appropriate

28. You have a right to information in sufficient time for decision making.

29. You have the right to access your records according to agency policy

30. You have a right to refuse concurrent or dual treatments for multiple problems

31. You have a right to not complete releases of information and right to revoke them, if already completed.

32. You have a right to an investigation and resolution of any alleged infringement of rights with in specific time frames. You will not face retribution or retaliation if you act in good faith in making a report

33. You have the right to contact a public payor (Department of Human Services, Department of Children and Family Services, Department of Rehabilitative Service and Department of Alcoholism and Substance Abuse)

34. To a description of the route of appeal available when you disagree with a facility's policies or procedures. You have the right to contact the Guardianship and Advocacy Commission and Equip for Equality if you feel your rights are being violated.

35. IMHC does not do human subject research.

Guardianship and Advocacy Commission
East Central Region Office
423 South Murray Road
Rantoul, IL 61866-2125
217-892-4611

Equip for Equality
115 North Neil Street
Suite 209
Champaign, IL 61820
800-537-2632

ALL RIGHTS SHALL BE PROTECTED IN ACCORDANCE WITH CHAPTER 2 OF THE MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE [405 ILCS 5].

I HAVE EXPLAINED THE ABOVE RIGHTS TO CLIENT AND IT IS MY BELIEF THAT THE CLIENT HAD UNDERSTOOD THESE RIGHTS.

CLIENT SIGNATURE: _____DATE:_____

GUARDIAN SIGNATURE _____DATE:_____

STAFF SIGNATURE: _____DATE:_____