Date: Name: Client ID:

ECKER CENTER FOR BEHAVIORAL HEALTH
Leading Individuals to a Healthier Life

Welcome to the Ecker Center for Behavioral Health. We hope that you find your care with us is helpful, supportive, and pleasant. Thank you for choosing the Ecker Center for your behavioral health needs. The Ecker Center offers a variety of services for mental health and substance use. Mental health services offered include residential care, therapy, psychosocial rehabilitation, case management, supported employment, psychiatry, nursing, and 24-hour crisis intervention. Substance use and gambling problem services offered include an intensive outpatient program, group and individual counseling, SMART Recovery groups, and court ordered DUI services.

Your health is important to us, so we have provided handouts with basic education on HIV and Tuberculosis. We have also included a handout on opioid overdose prevention and how to create a Psychiatric Advance Directive. These handouts are yours to review and keep for future reference.

In an effort to help you better utilize your treatment and understand the Ecker Center's procedures, we have created this outline of important information and guidelines. Your cooperation with these guidelines will assist us in providing care as quickly and efficiently as possible. Key information includes:

1. Your treatment will begin following a Comprehensive Assessment. Information from the assessments and your input will help us determine the services that you need.

2. Treatment is a collaborative process between you and your service providers. We are counting on you to partner with us to outline achievable goals and objectives to meet your treatment needs.

3. Treatment is focused on helping you address mental health concerns and/or any substance use and gambling concerns. Common approaches include problem-solving, learning new skills and/or assisting you to think and act in new ways. Medication may also be an important part of your treatment regimen.

4. Crisis situations can occur between scheduled appointments and the Center has services available 24 hours per day to help. In the event that you experience a crisis, please call our Crisis Services line at 888-ECKER-50 (888-325-3750), or 988. You may also go to Ecker's Crisis Stabilization Program (CSP) located at 1845 Grandstand Place, Elgin, IL 60123. Alternatively, you may go to our Psychiatric Emergency Program (PEP) site, located at Advocate Sherman Hospital (Address: 1425 N. Randall Rd, Elgin, IL 60123) which is located within the emergency department.

5. Regular attendance at appointments is necessary for effective treatment. Please attend all appointments consistently as scheduled.

6. Our telephone number is 847-695-0484. You can reach specific departments by extension. Additional information can be found at www.eckercenter.org

We are glad you have taken this first step by reaching out and requesting help and support. We look forward to providing care to you.

United Way

Date: Name: Client ID:

HIV INFECTION

The disease AIDS is caused by the human immunodeficiency virus (HIV). The virus may live in the human body for years and can be spread to other people even before any symptoms appear. HIV makes the body unable to fight infections and other diseases. These diseases and infections can kill. Most people get HIV by sharing needles or having sex with someone who already has the virus. The virus can attack anyone. It doesn't matter who you are or where you live. People can get HIV in the suburbs as well as the inner cities. They can get the virus through sex and needle sharing at schools or college as well as on the street.

So far there is no vaccine or cure for the HIV infection or AIDS in sight. Experts believe that HIV, and AIDS, will be around for many years. But you can learn how to protect yourself and those you love from HIV. Education and safe behavior are our best defense against the spread of the virus. This brochure will give you important facts about HIV infection and AIDS.

FACTS: AIDS IS CAUSED BY A VIRUS CALLED HIV.
HIV stands for a Human Immunodeficiency Virus. This is passed by the semen, vaginal discharges, or blood of HIV-infected people. Once it infects someone, HIV destroys the cells that defend the body. Without the cells that make up its immune system, the body cannot defend itself from illnesses. Disease and infections then move in without a fight. HIV also becomes part of the body's cells. The immune system begins its fight against HIV at the beginning of infection.

THE COURSE OF HIV INFECTION

FACT: AIDS IS THE RESULT OF HIV INFECTION.
It may take a long time (many years) before AIDS develops. When people have AIDS, their bodies' defenses (immune system) have been severely damaged by the effects of the AIDS viruses (HIV). When that happens, people who are HIV positive get many different kinds of infections and cancers. It is these illnesses that kill.

FACT: MOST PEOPLE WITH HIV OR AIDS GOT THE VIRUS BY HAVING SEX OR SHARING DRUG NEEDLES WITH SOMEONE WHO ALREADY HAD HIV.
Anyone who has the virus can pass it to others. Men with HIV can infect women as well as other men. Women can infect men as well as other women. Mother-to-child transmission of HIV in the U.S. has decreased dramatically due to the use of antiretroviral therapy. When pregnant women with HIV are given medication and deliver via c-section, it is rare that the baby will be infected. Babies can be infected during breast feeding from an HIV infected mom.

FACT: YOU CANNOT "CATCH" HIV LIKE YOU DO A COLD OR FLU.
Unlike many other viruses, HIV does not spread by traveling through the air. Even though HIV is sometimes found in saliva, the virus is not spread by saliva. HIV is very fragile and dies quickly outside the body. Also, skin without cuts or sores helps prevent germs including HIV from infecting us. For these and other reasons, HIV <u>cannot</u> be spread by –

- Shaking hands
- Toilet Seats
- Swimming pools
- Insects, including mosquitoes
- Hugging
- Straws, spoons, or cups
- Animals
- Sneezing
- Coughing
- Food
- A kiss

FACT: YOU CAN PROTECT YOURSELF FROM THE VIRUS.
It is safest not to have sex.
- Have sex only with a partner who is not infected, who has sex only with you, and who does not use needles or syringes.
- Protect yourself with a **latex condom** and spermicide if you do not know for sure if your partner is uninfected.
- Never use needles or syringes for any drug, including steroids, unless under a doctor's care.

FACT: LATEX CONDOMS ("RUBBERS") CAN HELP PROTECT YOU FROM HIV.
Latex condoms can help protect you and your partner from HIV. Birth control pills and diaphragms cannot. But you must use the condom the correct way. And you must use them every time you have sex (vaginal, anal, or oral) from start to finish. Condoms are not foolproof, because they can break, tear, or slip off.
A health educator/counselor can perform an oral HIV test called the Orasure. If you would like to be tested for HIV, please talk with your counselor.

Date: Name: Client ID:

TUBERCULOSIS FACTS - - TB Can be Cured

What is TB?
"**TB**" is short for a disease called **Tuberculosis**. **TB** is spread by tiny germs that can float in the air. The **TB** germs may spray into the air if a person with **TB disease** of the lungs or throat coughs, shouts, or sneezes. The people nearby can breathe TB germs into their lungs.
TB germs can live in your body without making you sick. This is called **TB Infection**. Your immune systems traps **TB** germs with special germ fighters. Your germ fighters keep **TB** germs from making you sick.

But sometimes, the **TB** germs can break away. Then they cause **TB disease**. The germs can attack the lungs or other parts of the body. They can go to the kidneys, the brain, or the spine. If anyone has **TB disease** they need medical help. If they don't get help, they can die.
If you have **TB disease**, you may:

- feel weak,
- lose your appetite,
- lose weight,
- have a fever, or
- sweat a lot at night

These are signs of **TB disease**. These signs may last for several weeks. Without treatment, they usually get worse.

If the **TB disease** is in your lungs, you may:
- cough a lot,
- cough up mucus or phlegm
- cough up blood, or
- have chest pain when you cough

You should always cover your mouth when you cough!

If you get **TB disease** in another part of the body, the symptoms will be different. Only a doctor can tell if you have **TB disease**.

Tuberculous Infection

An estimated 10 to 15 million persons (4% to 6% of the population) have inactive tuberculous infection (no disease). Studies in some areas have found that **over 20%** of inner city black and Hispanic intravenous drug users (IVDUs) have tuberculous infection.

A person who has tuberculous infection without disease:
- cannot spread infection to others.
- is not considered a case of tuberculosis.
- usually has, as the only evidence of infection, a positive reaction to the tuberculin skin test;
- usually has a negative chest x-ray and no symptoms of **TB**; and
- has TB bacteria in his or her body that, although inactive, *remain capable of causing disease at any time later in life.*

The great majority (about 90%) of new TB cases occur in persons who were infected in the past and whose immune system can no longer control their infection. Only a small proportion of new cases come from recently acquired infection.

HOW DO I KNOW IF I HAVE TB INFECTION OR TB DISEASE?

- A skin test is the only way to tell if you have **TB infection**. The test is "positive" if a bump about the size of a pencil eraser or bigger appears on your arm. This bump means you probably have **TB infection**.

Above information was drawn from the US Department of Health & Human Services CDC TB handout

Date: Name: Client ID:

Opioid Overdose and Naloxone Education & Training

What are common opioids?
Opioids include both heroin and prescription pain medications. Some common opioid pain medications include: hydrocodone (**Lorcet** and **Vicodin**), oxycodone (**Percocet**), long acting opioids (**OxyContin**, **MS Contin**, **Methadone**), and patches (**Fentanyl**). Other brand name opioid pain medications include **Opana ER**, **Avinza** and **Kadian**.

How do I know if someone is overdosing?

A person who is experiencing an overdose may have the following symptoms:

- Breathing is slow and shallow (less than ten breaths per minute) or has stopped
- Vomiting
- Face is pale and clammy.
- Blue or grayish lips and fingernails
- Slow, erratic, or no pulse.
- Choking or loud snoring noises
- Will not respond to shaking or sternum rub
- Skin may turn gray, blue, or ashen

Emergency First Aid for suspected opioid overdose:
If a person is exhibiting symptoms of an opioid overdose, these following life-saving measures should be taken immediately.

1. **Call 9-1-1**

You do not need to mention drug use when you call. Provide the following basic information:

- Give address and location
- Say, “I have a person who has stopped breathing and is unresponsive”

2. Check to see if they can respond

- Give them a light shake, yell their name, any response?
- If you don’t get a response, try a sternum rub (rub your knuckles in the middle of their chest where the ribs meet, for 10 seconds)

3. Perform Rescue Breathing
(Or perform CPR if known)

- Make sure nothing is in their mouth
- Tilt head back, lift chin, and pinch nose.
- Start by giving two breaths, making sure the chest rises
- If the chest does not rise, tilt the head back more and make sure you are plugging their nose

4. Give Naloxone

- Open one NARCAN nasal spray container
- Dispense one NARCAN spray into nostril
- Wait three minutes and give another spray of NARCAN using the second dispenser
- Continue rescue breathing, one breath every five seconds, while waiting for the Naloxone to take effect
- Give a second dose of NARCAN if there is no response in three-five minutes

Date: Name: Client ID:

5. After Naloxone: Monitor their Response

- Continue to monitor their respirations and perform rescue breathing if respirations are below ten breaths per minute
- Stay with them until help arrives. The Naloxone may wear off and the victim could start to overdose again

What is Naloxone?

Naloxone (also known as Narcan) is a medication that can reverse an overdose that is caused by an opioid drug. When administered during an overdose, Naloxone blocks the effects of opioids on the brain and restores breathing within two to eight minutes.

Naloxone has been used safely by emergency medical professionals for more than forty years and has only one function: to reverse the effects of opioids on the brain and respiratory system in order to prevent death. Naloxone has no potential for abuse.

If Naloxone is given to a person who is not experiencing an opioid overdose, it is harmless. If naloxone is administered to a person who is dependent on opioids, it will produce withdrawal symptoms. Withdrawal, although uncomfortable, is not life-threatening.

Naloxone *does not* reverse overdoses that are caused by non-opioid drugs, such as cocaine, benzodiazepines (e.g. Xanax, Klonopin and Valium), methamphetamines, or alcohol.

What are the risk factors for an opioid overdose?

Mixing Drugs
Many overdoses occur when people mix heroin or prescription opioids with alcohol, benzodiazepines, or anti- depressants. Alcohol and benzodiazepines (such as Xanax, Klonopin and Valium), are particularly dangerous because, like opioids, these substances impact an individual's ability to breathe.

Lowered Tolerance
Tolerance is your body's ability to process a drug. Tolerance changes over time so that you may need more of a drug to feel its effects. However, tolerance can decrease rapidly when someone has taken a break from using a substance whether intentionally (in treatment) or unintentionally (in jail or the hospital). Taking opioids after a period of not using can increase the risk of a fatal overdose.

Health Problems
Your physical health impacts your body's ability to manage opioids. Since opioids can impair your ability to breathe, if you have asthma or other breathing problems you are at higher risk for an overdose. Individuals with liver or kidney disease or dysfunction, heart disease or HIV/AIDS are also at an increased risk of an overdose.

Previous Overdose
A person, who has experienced a nonfatal overdose in the past, has an increased risk of a fatal overdose in the future.

NALOXONE KITS & EDUCATION SESSIONS ARE FREE and AVAILABLE
PLEASE CONTACT HERB STRICKLIN
847-695-0484 X 3002
ECKER CENTER FOR BEHAVIORAL HEALTH

Date: Name: Client ID:

Create a Psychiatric Advance Directive

A Psychiatric Advance Directive serves a similar purpose as a crisis plan, but is a legal document created when a person is well. It describes what kind of mental health treatment you allow and who can make decisions about your care if you become unable. Only you can decide if you want to create an advance directive and what it contains.

There are two types:

A Declaration for Mental Health Treatment includes your preferences about:

- Medication
- Hospitalization
- Electroconvulsive Therapy (ECT)
- Your Attorney in Fact (any person chosen by you who can view your mental health records and make decisions about your care on your behalf)

A Power of Attorney for Health Care:

- Is any person chosen by you in advance.
- Can direct both your mental health treatment and other medical care.

Psychiatric Advance Directives are legal documents, so you should get advice from people who have experience with them. It is important to be well informed about the process and involve persons you can trust. Psychiatric Advance Directives are voluntary.

Free advice and assistance are available through:

Equip for Equality: Main Office

- Call: (800) 537-2632
- TTY: (800) 610-2779
- Visit: www.EquipForEquality.org

Illinois Guardianship and Advocacy Commission

- Call: (866) 274-8023
- TTY: (866) 333-3362
- Visit: www.GAC.State.IL.US

You may obtain sample Advance Directive forms from the Illinois Department of Public Health:

- Visit: www.idph.state.il.us/public/books/advin.htm
- Call: (217) 782-4977

Date: Name: Client ID:

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION (PHI) BY ALTERNATE MEANS

Current Mailing Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the Ecker Center for Behavioral Health to leave a voicemail or message as described below. I understand that this voicemail or message may contain my protected health information.

Can we leave detailed messages on your voicemail?

Yes☐ No☐

If Yes, please complete the below.

☐ May leave detailed message on voicemail:
Home #: _____
Cell #: _____
Work #: _____
Other #: _____

☐ May leave detailed information with: _____ (Name) _____ (Relationship)

☐May provide text/email appointment reminders to:

_____ (phone) _____ (email address)
*text/data rates may apply

Please note that "detailed information" may include information about appointments, insurance and billing, referrals to other clinicians, and/or lab tests. If a selection is not made above, Ecker Center staff will leave voicemails or messages stating only their name, the service provider, appointment information (date and time), and a call-back number. If the phone number is not active, information may be mailed to the address listed above.

AUTHORIZATION TO LEAVE PHI BY ALTERNATE MEANS

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify Ecker Center if I would like to change one or more of the telephone numbers listed above.

_____ _____ _____ _____
Signature of Client Date Staff Signature Date

(Clients 12 to 17 of age must sign in addition to the Parent or Legal Representative. If signed by the Legal Representative, indicate the relationship to the client or authority to act for the client.)

_____ _____ Relationship: _____
Signature of Parent or Legal Representative Date

Date: Name: Client ID:

RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS:

1. To maintain all your legal rights and be provided mental health and substance abuse services in the least restrictive setting.
2. To give or withhold informed consent regarding treatment and regarding confidential information about the client.
3. To individualized service, to participate in treatment planning, and to have access to qualified staff.
4. To request the opinion of a consultant at personal expense and to request a review of your treatment plan.
5. To know the professional status of the staff members responsible for your care.
6. To be free of abuse, exploitation, and neglect by agency employees. If you feel this right has been violated, you may contact the Office of the Inspector General at 1-800-368-1463.
7. To know the risks, side effects, benefits, and/or experimental nature of treatment procedures.
8. To know the alternative treatment procedures available, to refuse treatment, and to know the consequences for treatment refusal.
9. To know the cost of services rendered and to know if limitations to duration of care exist.
10. To know how to initiate a complaint or grievance procedure. The complaint or grievance can be presented up to & including the CEO. Grievances will be reviewed with the client & a director will come to a decision within 10 business days.
11. To contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
12. To contact/be informed by HFS or its designee of your healthcare benefits and the process for reviewing grievances.
13. To contact the agency's management about client care and safety at the agency.
14. To see your clinical record and ensure confidentiality of clinical records regardless of whether or when the client ceases to be a patient.
15. Any records containing HIV/AIDS status will be kept in a separate confidential file and be accessed on a need to know basis only, with permission from the program director.
16. Not be required to release any information regarding HIV/AIDS status as a condition of treatment.
17. You have the right to confidentiality as governed by the Confidentiality Act [740 ILCS-110], Alcohol and Drug Abuse Regulations [42 CFR 2 2020] [20 ILCS 301/Art.30] and Health Insurance Portability Accountability Act of 1996, except:
    a) When you are reasonably expected to inflict serious harm upon yourself or another in the near future.
    b) When you are unable to provide for your basic needs or guard yourself from serious harm.
    c) When you are suspected of child abuse or neglect.
    d) When you are in need of emergency care.
    e) When a crime has been committed at the organization or a threat to commit such crime.
    f) When communication of information between or among personnel having a need for the information in connection with their duties either within the organization or with an entity having direct administrative control over the services.
    g) When disclosure of information as authorized by an appropriate court order upon showing of good cause, after appropriate procedure and notice, and with appropriate safeguards against unauthorized disclosure.
    h) When such disclosure is necessary to collect sums representing charges for services for the purpose of conducting audit evaluation activity or scientific research.
    i) For other reasons as listed in the Mental Health and Developmental Disabilities Code [405 ILCS-5].
    j) When receiving DUI evaluation or risk education intervention services, offender information can be released by allowed by law.
18. To not be denied, suspended, or terminated from service, or have services reduced for exercising any of these rights or on the basis of age, sex, race, religious beliefs, ethnic origin, marital status, disability, sexual orientation, gender identity, HIV status, or criminal record.
19. If you believe that the Center's staff has not adequately addressed your patient care and/or safety concerns, other organizations will consider your concerns. You have the right to contact any of the following accreditation or advocacy agencies or public payers or ask for assistance from staff in contacting these groups:
    a) *Guardian and Advocacy Commission is 4302 N Main St # 108, Rockford, IL 61103, (815) 987-7657
    b) *Protection and Advocacy, Inc. (Equip for Equality) is 11 E. Adams, Chicago, IL 60601, 312-341-0022 or hotline 1-800-537-2632
    c) *Department of Human Services is 100 W. Randolph, Suite 6-400, Chicago, IL 60601, 312-814-2753
    d) *The Illinois Department of Human Services Substance Use Prevention and Recovery, 401 S. Clinton St. Second Floor, Chicago, IL 60607, 312-814-3840, DoIT.SUPRHelp@illinois.gov
    e) *Department of Corrections is 100 W. Randolph, Suite 4-200, Chicago, IL 60601, 312-814-2955
    f) *Department of Children and Family Services is 100 W. Randolph, Suite 6-200, Chicago, IL 60601, 312-814-4650
    g) *Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181, 630-792-5000
    h) *Illinois Mental Health Collaborative for Access and Choice, P.O.Box 06559, Chicago, IL 60606, 866-359-7953, TTY 866-880-4459
    i) *Illinois Department of Healthcare and Family Services 201 S. Grand Ave E, Springfield, IL, 62763, 800-226-0768
20. Your rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5].
21. The right to have disabilities accommodated and nondiscriminatory access to services as required by the American with Disabilities Act of 1990 (42 USC 12101) sect. 504.of the Rehabilitation Act & the Human Rights Act[775 ILCS 5].

Date: Name: Client ID:

YOUR RESPONSIBILITIES:

1. Give information regarding past illnesses, hospitalizations, medications, and other information relating to your health, including any cultural values or special communication needs.
2. To inform us of any current or anticipated involvement in civil or criminal litigation for which you would be requesting our assistance via records, reports or testimony.
3. Ask questions if the proposed course of treatment is not understood.
4. Participate in your care by following mutually agreed upon treatment plans including giving permission to communication with referral sources or other collaborating entities involved in your care.
5. Cooperate and assist in making discharge plans in a responsible and timely manner.
6. Be considerate of other clients and staff in limiting noise, disruption, refraining from offensive language and in following sanitation and smoking restrictions.
7. Be responsible for the behavior of your minor children brought to the agency.
8. Respect other's property and that of the agency.
9. Refrain from bringing alcohol, illegal drugs, weapons, including concealed firearms, or items intended to be used as weapons on to Ecker premises.
10. Follow written rules and behavior, which are specific to the area or service on which you are being treated.
11. Keep scheduled appointments or cancel them within 24 hours.
12. Arrange for timely payment for services rendered.

I HAVE READ AND RECEIVED THE ABOVE RIGHTS AND RESPONSIBILITIES AND AGREE TO COMPLY WITH THESE POLICIES. THIS INFORMATION WAS PROVIDED TO ME IN A LANGUAGE OR METHOD OF COMMUNICATION I UNDERSTAND.

_____ _____ _____ _____

Signature of Client Date Staff Signature Date

(Clients 12 to 17 of age must sign in addition to the Parent or Legal Representative. If signed by the Legal Representative, indicate the relationship to the client or authority to act for the client.)

_____ _____ Relationship: _____

Signature of Parent or Legal Representative Date

Client ID #

Date: Name: Client ID:

CLIENT AGREEMENTS, AUTHORIZATIONS, AND INFORMATION

Parent/legal rep and client please read each section and initial below:

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Ecker Center for Behavioral Health and its employees or designees or its designees (e.g., contractors, interns, staff working under supervision). I authorize behavioral and physical health care services deemed necessary or advisable by my caregivers to address my needs. I understand that there are risks and benefits, possible alternatives, and costs included in treatment.

I understand that I am freely consenting to behavioral health services at the Ecker Center for Behavioral Health. I understand that following an assessment, I may be eligible for other services offered at the Ecker Center including crisis intervention, individual and group therapy, case management, vocational assistance, psychosocial rehabilitation, mental health residential support, and psychiatric care, including medication for mental health and substance use. I have also been given a copy of the client fee agreement and understand my financial responsibility. My signature on this form signifies that all the above information is correct. X_____
X_____

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 Center. I authorize the Center to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Center may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company, its designated agent, SAMHSA, or, if I reside in Hanover Township, the Hanover Township Mental Health Board that provides funding to support Ecker Center services. X_____
X_____

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE
I authorize payment to be made directly to the Center for insurance benefits payable to me. I understand that I am financially responsible to the Center 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's fees. X_____
X_____

FOR DEAF, HEARING AND SPEECH ASSISTANCE
Illinois Relay Center at 711

FOR VISION IMPAIRED
Telebraille at 877-526-6670

TO REPORT ABUSE
OIG Hotline (1-800-368-1463) takes reports of allegations of adult abuse or neglect by community agency personnel. Consumers over 59 years old who report to OIG should also report the allegation to the Elder Abuse Hotline at 1-800-252-8966 from 8:30 A.M to 5:00 P.M. Monday through Friday or to 1-800-279-0400 at all other times. To report suspected child abuse or neglect call the DCFS Hotline at 1-800-25-ABUSE.

MEDICARE COVERED AND NON-COVERED SERVICES MEDICARE #_____
The Ecker Center for Behavioral Health accepts Medicare assignment for covered services. Medicare reimbursable services must be provided by a Physician, Advanced Practice Nurse, or Licensed Clinical Social Worker (LCSW). While we try our best to accommodate requests for therapy with a Licensed Clinical Social Worker, there is a high demand on our limited resources, and we may not be able to grant all requests. Services not covered by Medicare will be billed to you.

I request that payment of authorized Medicare benefits be made on my behalf to Ecker Center for Behavioral Health for any services furnished me by the Ecker Center for Behavioral Health. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If items 2 and 12 of the HCFA-1500 Claim Form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the Ecker Center for Behavioral Health agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. X_____
X_____

_____ _____ _____ _____
CLIENT SIGNATURE DATE PARENT/LEGAL REPRESENTATIVE SIGNATURE DATE

AGREEMENT RELATED TO CIVIL LITIGATION
If you need an expert witness for your legal case, you should hire, with your own money, a psychiatrist, psychologist, therapist or other professional that you require because the Ecker Center is not funded to provide expert witness service. If you insist on calling on our service providers to testify in a legal case, our charges and other requirements will be:

- $100 an hour for report writing, with a $100 minimum fee
- $200 an hour for testimony and travel, with a minimum $200 fee, which will also be charged if testimony is cancelled or rescheduled with less than 48 hours' notice
- Testimony scheduled at a time convenient for our service provider
- Your attorney must call our service provider one hour before testimony is required, so our staff do not have to wait to testify at a location outside of their office

I understand that the Ecker Center's purpose is to provide treatment and recovery services to persons with behavioral health needs and not to provide expert witnesses in litigation. X_____
X_____

Date: Name: Client ID:

PRIVACY POLICY. I acknowledge having received the Center's "Notice of Privacy Policies." My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are 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 Center has already made disclosures with my prior authorization. X_____
X_____

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. Effective Date: April 14, 2003 and modifications as of September 22, 2013.
We respect patient confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by Ecker Center for Behavioral Health.
Privacy Contact: If you have any questions about this policy or your rights contact Medical Records at (847) 695-0484.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond our Agency. This includes for:
Treatment: We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our Agency that we are consulting with or referring you to.
Payment: With your written consent on the Patient Agreements and Authorization document, information received will be used to obtain payment for your treatment and services. This information will include contacting your health insurance company for prior approval of planned treatment or for billing purposes and the release of your demographics and services received to the State of Illinois and SAMHSA. You have a right to restrict certain disclosures of your protected health information if you pay out of pocket in full for the services provided to you.
Healthcare Operations: We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.
Information Disclosed Without Your Consent: Under Illinois and federal law, and funders' contracts, information about you may be disclosed without your consent in the following circumstances:
Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.
Follow Up Appointments/Care: We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will leave appointment information via our standard methods of communication, unless you request otherwise in writing.
As Required by Law: This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.
Coroners: We are required to disclose information about the circumstances of your death to a coroner who is investigating it.
Governmental Requirements: We may disclose information to a health oversight agency or funding entity for activities authorized by law or contract, such as audits, investigations, inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the U.S. Department of Health and Human Services to determine our compliance with federal laws related to health care and to Illinois state agencies and SAMHSA that fund our services or for coordination of your care. A non-identifiable ID is assigned to protect health information shared to comply with federal grant reporting requirements of SAMHSA.
Criminal Activity or Danger to Others: If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.
Fundraising/Marketing: As a not for profit provider of health care services we need assistance in raising money to carry out our mission. We may contact you to seek a donation. You will have the opportunity to opt out of receiving such communication. We will not provide your contact information for any marketing that results in compensation to the Agency without your permission.

PATIENT RIGHTS

You have the following rights under Illinois and federal law:
Copy of Record: You are entitled to inspect the medical record our Agency has generated about you. We may charge you a reasonable fee for copying and mailing your record.
Release of Records: You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization. Except as described in this Notice or as required by Illinois or federal law, we cannot release your protected health information without your written consent.
Restriction on Record: You may ask us not to use or disclose part of the medical information. This request must be in writing. The Agency is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the **HIPAA Privacy Officer.**
Contacting You: You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. We also will provide you with information by email if you request it. If you wish us to communicate by email you are also entitled to a paper copy of this privacy notice.
Amending Record: If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the clinician you are working with and ask for the *Request to Amend or Modify Medical Record* form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.
Accounting for Disclosures: You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release.
To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to our **HIPAA Privacy Officer**. We will notify you of the cost involved in preparing this list.
Notification of Breach: You will be notified if there is a breach or a violation of the HIPAA Privacy Rule and there is an assessment that your protected information may be compromised. You have a right to be notified if there is a breach of your unsecured protected health information. This would include information that could lead to identity theft.
Questions and Complaints: If you have any questions or wish a copy of this Policy or have any complaints you may contact our **HIPAA Privacy Officer.** in writing at our office for further information. You also may complain to the Secretary of the U.S. Department of Health and Human Services if you believe our Agency has violated your privacy rights. We will not retaliate against you for filing a complaint.
Changes in Policy: The Agency reserves the right to change its Privacy Policy based on the needs of the Agency and changes in state and federal law.
03/2023

Date: Name: Client ID:

ECKER CENTER FOR BEHAVIORAL HEALTH

Notification of Primary Physician Form

It is recommended that you confer with your primary care physician regarding your behavioral health needs. If you have a primary care physician, the Ecker Center will notify him/her that you are seeking or receiving behavioral health treatment unless you waive such notification.

Please indicate your wishes below by checking the appropriate item:

☐ My primary physician is _____

Address: _____

☐ I agree to your notifying my primary care physician that I am seeking or receiving behavioral health services. I am signing the attached *Release of Information* Form permitting you to communicate with my physician.

☐ I WAIVE NOTIFICATION of my primary care physician that I am seeking or receiving behavioral health services, and I direct you, **NOT** to notify them.

☐ I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFCATION of a primary care physician that I am seeking or receiving behavioral health services.

_____ _____
Date Client signature

_____
Parent or Legal Representative signature

_____
Staff Witness Signature

For Medical Records use. Information Sent: ____ Yes ____ No

Notification of Primary Physician of Patient Receiving Behavioral Health Services

You are hereby notified that _____ is seeking or receiving services from Ecker Center for Behavioral Health. The patient has signed a *Release of Information* Form, a copy of which medical records is enclosing for your records. The Ecker Center looks forward to the opportunity to confer with you about this patient as the occasion or need arises.

_____ _847-695-0484_____
Ecker Center Staff Phone

Date: Name: Client ID:

ECKER CENTER FOR BEHAVIORAL HEALTH
Leading Individuals to a Healthier Life

Telehealth Consent Form

I (name) _____ agree to receive telehealth services through Ecker Center for Behavioral Health. This Consent form applies to telehealth services that do not originate from a prearranged secure location. A telehealth service means that my visit with the provider at the distant site will happen by using a home computer, mobile device, or landline telephone. This consent will expire upon termination from services at Ecker Center for Behavioral Health.

I also understand that:

- I can decline telehealth services at any time without it affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- If I decline the telehealth services, the other options/alternatives available for me will be in-person services subject to provider availability
- The use of telehealth to deliver counseling services may create potential risks to the confidentiality of information shared in individual or group sessions, as other household members may overhear personal information shared.
- Telehealth services can only be provided if I am in the state of Illinois at the time of service.

I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Client _____Date:_____

Signature of Parent/Legal Representative _____ Date:_____

(Clients 12 to 17 of age must sign in addition to the Parent or Legal Representative. If signed by the Legal Representative, indicate the relationship to the client or authority to act for the client.)

Relationship: _____

Signature of Staff Obtaining Consent: _____ Date: _____

LPHA Signature: _____ Date: _____

🌿 Smoke-Free Campus Policy: Guidelines

To promote a healthier and cleaner environment for all clients, staff, and visitors, our organization is proud to maintain a **100% smoke-free campus**. This includes the use of cigarettes, cigars, vaping devices, e-cigarettes, and any tobacco, nicotine, or marijuana products.

🚫 Where Smoking is Not Allowed

Smoking, vaping, or use of any related products is prohibited in the following areas:

- All indoor spaces within the organization
- All outdoor areas, including parking lots, sidewalks, and personal vehicles while on Ecker property
- Entrances, exits, and all common areas

✅ Your Role

We ask all individuals to:

- **Refrain from smoking** or using related products while on the Ecker campus
- **Properly dispose** of smoking materials in appropriate receptacles — *littering is prohibited by Illinois law (415 ILCS 105/)* and may result in penalties
- **Respect staff reminders** and signage indicating our smoke-free policy

🔍 Important Note on Local Law

In accordance with **Illinois state law**, smoking must occur at least **15 feet away** from any public building entrances, exits, windows, or ventilation intakes — including areas adjacent to, but not on, Ecker property.

🎥 Campus Monitoring & Accountability

To ensure the safety and cleanliness of our environment, **our campus is monitored by security cameras**. Individuals found in violation of our smoke-free or littering policies may be subject to further review and consequences in accordance with Ecker guidelines and state regulations.

💡 Need Help Reducing or Quitting?

We understand that quitting tobacco or nicotine use is a personal journey. **Support is available!** Ask us about free and confidential tobacco cessation resources.

🤝 We're Here to Help

Thank you for helping us maintain a healthy and welcoming environment for all. If you have questions or need assistance, please reach out to your Ecker clinician or visit the front desk of our main location.

Acknowledgment

I acknowledge that I have read, understand, and agree to the information outlined above.

Signature: _____ **Date:** _____

Printed Name: _____