Client Theranest #: _____

Northeast DuPage Family & Youth Services
3 Friendship Plaza, Addison, IL 60101
630-693-7934

Informed Consent Disclosure & HIPAA Agreement

Treatment Process:

Counseling/therapy is a voluntary process which involves examining and changing thoughts, feelings, and behaviors. Successful counseling/therapy involves a commitment to this process, often including regular sessions (typically biweekly or weekly). Successful counseling/therapy also requires you, and possibly your support persons or other providers, to be actively involved in sessions and homework between sessions.

Treatment at this agency begins with an assessment. This assessment determines if this agency is able to provide services or treatment appropriate for your needs. Based on your assessment, your therapist may assign a diagnosis, which will be recorded in your file. Based on your assessment and/or response to treatment, your counselor/therapist may recommend further assessments/services at other providers, including a psychiatric evaluation, a psychological evaluation, or medical evaluation. Completing these recommendations is voluntary, but may help your treatment to be more effective by providing additional insight. This agency provides multiple styles of counseling/therapy, including but not limited to: individual therapy, couples therapy, family therapy, and group therapy. Your therapist will discuss with you which type(s) is/are recommended based on your assessment and response to treatment. It is up to you if you decide to engage in the recommended treatment, but the agency may decline to offer further services if you decline recommended services.

Potential benefits of counseling/therapy include obtaining a professional opinion and changing troubling thoughts, feelings, or behaviors. Risks of counseling/therapy may include confronting difficult emotions, memories, or conversations. Any negative response to treatment should be shared with your counselor/therapist.

Client Rights and Responsibilities:

1) Sessions with a counselor/therapist are confidential, with some exceptions. The following are some exceptions:
   - If you are in counseling/therapy by an order of the court, the results of treatment ordered must be revealed to the court.
   - In the event of a mental health emergency, defined by threat to harm yourself or another individual, your counselor/therapist will complete an assessment of risk, and may recommend further assessment (known as an emergency psychiatric evaluation) at a local

emergency room or other location. Your cooperation with these recommendations is requested. If you decline a recommendation, your therapist may act to ensure your safety, including, but not limited to: contacting local authorities to conduct a safety check, contacting your emergency contact, warning the person threatened, involving your parents/guardian, requesting a court-mandated psychiatric evaluation, contacting DCFS, or contacting 911.

- If physical abuse, sexual abuse, or neglect to any minor child or vulnerable adult is suspected, the counselor/therapist must report his or her knowledge or suspicions to the appropriate authorities.
- If you are under 18 or have a guardian, the counselor/therapist reserves the right to advise parents or legal guardians about developments that could significantly affect your health or wellbeing.
- If you are between the ages of 11 and 17, your parent/guardian consents to have your assessment and treatment plan information entered into eCornerstone and updated every 90 days.
- If you elect to sign a release of information, the information defined on the release of information may be shared.
- If you elect to share during a couple's, group, or family session, the agency cannot guarantee that information will not be shared by the other clients within the group.
- If you elect to communicate with the agency by text or email, the agency cannot guarantee the information will remain confidential, as texting and email are not generally considered secure forms of communication.
- If the agency receives a court order to provide information in your record or testify, the agency may be mandated to comply.
- If you bring suit against the agency or a current or former staff at the agency, the agency may utilize information in your record to defend its actions.

2) The counselor/therapist may consult and seek supervision with another professional(s) about your assessment and/or treatment.

3) If you are coming in for legally mandated treatment, the counselor/therapist will ask you to sign a release of information form. The counselor/therapist reserves the right to report the status of your attendance.

4) If you have previously been a client, the counselor/therapist may consult your prior files for more information.

5) You will be asked to complete a set of assessments before, during, and at the end of treatment. These assessments will help structure your treatment plan and monitor progress and effectiveness.

6) The agency is not capable of meeting the needs of all clients for all treatment issues. Following your assessment, your counselor/therapist will discuss the treatment options

available, as well as your appropriateness for treatment at this agency. If this agency determines it cannot meet your needs, you will be provided three referrals.

7) You have the right to ask questions and to actively participate in the setting of goals at the beginning and throughout treatment.

8) Please arrive promptly for your appointments. If you are more than fifteen minutes late, your session may be cancelled.

9) If you are unable to attend a scheduled appointment, please provide 24 hours of notice. If you miss or provide less than 24 hours of notice on multiple occasions, your therapist will discuss this with you and may recommend modification of your appointments or termination of treatment.

10) If you come to a session under the influence of alcohol or other illegal substances, the session will be terminated. If you have driven, have a guardian, or are under 18, your therapist reserves the right to notify your parent/guardian, contact your emergency contact, and contact the appropriate authorities as needed to protect your safety.

11) This agency utilizes interns and unlicensed clinicians to provide treatment services. All unlicensed interns and clinicians are supervised by a fully licensed therapist/counselor.

12) This agency utilizes a cloud-based electronic health record to maintain client files. Clients seeking services at this agency agree to the maintaining of their files in this system

Termination of Counseling/Therapy:

Treatment is voluntary. You may elect to end treatment at any time for any reason. Treatment may end for the following reasons, among others:

- Counseling/therapy may end based on mutual consent.
- Counseling/therapy may end if you have completed the number of contracted sessions.
- Counseling/therapy may end if have met your treatment goals.
- Counseling/therapy may end if you fail to comply with treatment recommendations.
- Counseling/therapy may end if the agency determines your needs cannot be met with the services the agency provides.
- Counseling/therapy may end if you harass, threaten, or harm any property, staff, or another client at the agency.
- Counseling/therapy may end if you are not seen face-to-face for 30 or more days.

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HIPAA Agreement:

You have rights under the Health Insurance Portability and Accountability Act. This act is designed to provide policy standards to protect patients' medical records and other health information. A copy of your HIPAA rights is available to you at https://www.nedfys.org. If you would like a hard copy of NEDFYS' HIPAA Privacy Notice, you may ask your clinician or another NEDFYS staff member at any time and it will be provided to you.

Your signature below indicates that you have been offered the opportunity to receive and review NEDFYS' HIPAA Privacy Notice and that you agree to its terms.

Emergencies:

In case of an emergency, the counselor/therapist may contact:

_____

(Name) (Relationship) (Telephone #)

My signature below indicates that I have been informed of and understand my rights and give my consent for treatment at Northeast DuPage Family & Youth Services.

X_____

(Client Signature)

X_____

(Printed Name of Client)

X_____

(Parent Signature – if minor)

X_____

(Witness Signature)

_____

(Date)