Aspen COUNSELING & Consulting, L.L.C.

New directions in emotional health and wellbeing

Client Intake Packet

We welcome you as a new client. Please take the time to fill out the forms in this packet as accurately as possible so we can most appropriately address your emotional health.

The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

An affiliate of Rosecrance Health Network

10/26/2020

Registration Form

Aspen COUNSELING & Consulting, L.L.C.

Client information

Date of registration:_____ Referred by: _____

Client name:_____ Sex: _____

SS #: _____ - ____ - _____ DOB: _____ Age: _____

Address: _____ City/State/Zip: _____

Phone number:_____ Alternate phone: _____

Email address:_____

Are you employed? ☐Yes ☐ No **Type:** ☐ Full-time ☐ Part-time ☐ Retired ☐ Student **Shift:** ☐ Day ☐ Night ☐ Varied

Employer:_____ Occupation: _____

Address:_____ City/State/Zip:_____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency contact: _____ Relationship: _____ Phone number:_____

Parent/Guardian information

Name:_____ Relationship to client: _____

DOB:_____ Phone number:_____

Address (if different from client): _____ City/State/Zip: _____

Billing information *(Please complete if person responsible is not the client)*

Name of responsible party:_____ Relationship to client: _____

SS #: _____ DOB: _____ Address: _____

City/State/Zip: _____ Home phone:_____ Cell phone:_____

Employer: _____ Address: _____ City/State/Zip: _____

Insurance information (Please provide your insurance card to make a copy)

Name of policyholder: _____ DOB:_____ Employer: _____

Address: _____ City/State/Zip: _____ Phone:_____

Relationship to insured: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Child ☐ Other

Insurance company: _____ Member ID #:_____ Group #: _____

If you have secondary insurance, please complete below:

Name of policyholder: _____ DOB: _____ Employer: _____

Address: _____ City/State/Zip: _____ Phone: _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Child ☐ Other

Insurance company: _____ Member ID #:_____Group #: _____

Intake Assessment and Questionnaire

Aspen COUNSELING & Consulting, L.L.C.

Date: _____

Client name: _____

Presenting problem

Please check if you are experiencing any of the following concerns:

- ☐ Alcohol/drug abuse
- ☐ Marital/Relationships
- ☐ Sexual issues/Orientation
- ☐ Death/Grieving
- ☐ Family/Friends
- ☐ Physical health
- ☐ Occupational/Financial
- ☐ Mood swings
- ☐ Stress management
- ☐ Anxiety
- ☐ Depression
- ☐ Other: _____

Please describe how and for how long this concern has been affecting you: _____

_____

_____

Goals for treatment: _____

_____

_____

Psychiatric history

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions? ☐ Yes ☐ No

If yes, what and when? _____

_____

Have you ever seen a counselor/therapist before? ☐ Yes ☐ No

If yes, by whom? _____

What did you enjoy/dislike about therapy? _____

What symptoms or problems led you to seek treatment in the past? _____

_____

Have you ever been hospitalized for an emotional problem or psychiatric illness? ☐ Yes ☐ No

If yes, where and when? _____

_____

Have you ever intentionally hurt yourself or made a suicide attempt? ☐ Yes ☐ No

If yes, how and when? _____

_____

Medical history

Please check if you are currently experiencing or have ever experienced:

- ☐ Head injury
- ☐ Heart (trouble, disease, surgery)
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Fainting spells
- ☐ Abnormal blood pressure
- ☐ Anemia
- ☐ Thyroid problem
- ☐ Kidney or bladder problems
- ☐ Liver disease
- ☐ Skin rashes/sores
- ☐ Hepatitis—type A, B, or C
- ☐ Asthma or hay fever
- ☐ Sinus problems
- ☐ Weight change/Change in appetite
- ☐ Glaucoma/Cataracts
- ☐ Neurological disorders
- ☐ Memory loss/forgetfulness

Intake Assessment and Questionnaire (cont.)

Aspen COUNSELING & Consulting, L.L.C.

- ☐ Ulcers/Abdominal pain
- ☐ Epilepsy (seizure disorder)
- ☐ Lung disease or conditions
- ☐ Cancer/Tumors
- ☐ Excessive fatigue
- ☐ Arthritis
- ☐ Severe headaches
- ☐ Hemophilia/blood disease
- ☐ Sickle Cell disease
- ☐ Night sweats
- ☐ HIV positive/AIDS/ARC
- ☐ Hearing impaired
- ☐ Visual problems
- ☐ Persistent cough
- ☐ Other: _____

Please explain any checked items above (major illnesses, surgeries, recent hospitalizations, etc.):_____

_____

Are you currently experiencing any physical pain? ☐ Yes ☐ No If so, where? _____

Are you currently receiving care for your pain? ☐ Yes ☐ No If so, by whom?_____

Primary care physician: _____ Phone: _____

Address: _____

Date of last medical exam: _____

Please list any allergies (especially to medications): _____

_____

Current medications (Please include all prescription and over the counter medications)

Medications	Dosage and frequency	Reason	Physician

Do you use recreational drugs? ☐ Yes ☐ No

If so, please list type and frequency: _____

Please indicate which pharmacy you would like prescriptions sent (if applicable):

Name of pharmacy:_____

Address:_____ City/State/Zip:_____ Phone:_____

Intake Assessment and Questionnaire (cont.)

Aspen COUNSELING & Consulting, L.L.C.

Family/social history

Briefly describe your relationship with your parents and siblings (if applicable): _____

_____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Briefly list number of marriages, how long married, and reason for divorce (if applicable): _____

_____

Who currently lives in your household? _____

_____

Is there a history of depression, anxiety, substance abuse, or other mental health conditions in your family? ☐ Yes ☐ No

If yes, who? What was the problem? Did they receive treatment? _____

_____

_____

Did you grow up in a home in which a parent/guardian abused drugs or alcohol? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever experienced emotional, physical, or sexual abuse? ☐ Yes ☐ No

If yes, please explain: _____

Educational and vocational history

What is the highest grade level you completed? _____ Do you have a GED? _____

How did you do academically in school? _____

Did you attend college? ☐ Yes ☐ No If yes, where and what is your degree? _____

What is your current occupation? _____ For how long? _____

Do you like your job? ☐ Yes ☐ No Have you ever been fired? _____

Do you have any language or reading difficulties? _____

Are you having any current financial difficulties? _____

Military history

Have you ever served in the military? ☐ Yes ☐ No If yes, what branch? _____

Date/Type of discharge: _____ Combat history? _____

Legal history

Please indicate any past or current legal history:

Arrests	☐ Yes ☐ No	Explain: _____
Restraining order	☐ Yes ☐ No	Explain: _____
Divorce/Custody	☐ Yes ☐ No	Explain: _____
Incarceration	☐ Yes ☐ No	Explain: _____
Probation	☐ Yes ☐ No	Explain: _____

Client Financial Agreement

Aspen COUNSELING & Consulting, L.L.C.

Client name: _____

Responsible party name: _____

(if different from client)

- Full payment is due at the time of services. All co-pays, deductibles, and co-insurance must be paid prior to receiving services.
- Please notify the office of any changes to your insurance plan.
- You are responsible for obtaining any required referrals prior to your first visit.
- Failed appointments or appointments cancelled with less than 24 hours advance notice will result in a $75.00 fee.
- All appointment cancellations must be made by phone.
- Aspen Counseling & Consulting LLC reserves the right to suspend services if your account is past due.

You may pay at the time of service or you may store a credit or debit card that will be charged for any amount due.

Please indicate your choice:

☐ **I will pay at the time of service.** I agree to reschedule appointments if I cannot pay the full amount. I understand that future appointments may be cancelled if I fail to make payments at the time services are provided.

☐ **I authorize Aspen Counseling & Consulting, LLC to securely store my credit or debit card information through its electronic processing vendor, MX Merchant.** I authorize my credit or debit card to be charged at the time of service for any amounts due. I further authorize Aspen Counseling and Consulting, LLC to charge my credit or debit card for any future services.

Name on card: _____

Address: _____

Credit card number: _____

Expiration date: _____/_____ Security code: _____ Zip code: _____

Cardholder's signature: _____ Date: _____

This authorization is valid for one year from the date signed. You can opt out of auto payments at any time by contacting our office at 815-399-9700.

I accept the terms of this agreement.

Client's /responsible party's signature: _____ Date: _____

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ROSECRANCE AND AFFILIATES
Financial Release of Information

Client Name: _____ Client ID: _____ Client DOB:_____

Release of Information
This release of information is to secure payment for services provided by Rosecrance Health Network and Affiliates ("Rosecrance") and applies to the following information: *your presence in treatment; your demographic and medical information; treatment information and records including assessment, diagnosis, treatment plan, dates of service, type of service and level of care received; financial information; and any other information that is necessary to obtain authorization for services, to determine eligibility, to coordinate benefits, to submit health care claims, and to obtain reimbursement from a third-party payer or funding source.*

Indicate which of the following entities, payers, or funding sources are allowed to exchange information with Rosecrance:

X	Name	Description
		Parent/Guardian/Spouse
		Parent/Guardian
		Third Party Payer
		Third Party Payer
	Illinois Department of Human Services ("DHS"), Healthcare & Family Services ("HFS") ("Medicaid")	**Third Party Payer**
	Centers for Medicare & Medicaid Services ("Medicare")	**Third Party Payer**

Insurance Plan Information
I hereby authorize my plan administrator, the plan fiduciary, the insurer, and my attorney to release to Rosecrance any and all Plan documents, summary plan benefit description, insurance policy, medical necessity criteria, reasons for denial, and settlement information upon written request from Rosecrance or its attorneys in order to claim benefits or to pursue any internal or external appeal or legal or administrative remedies.

Parent Companies and Subsidiaries
I authorize Rosecrance to exchange information with the entities listed above and any wholly owned subsidiaries owned by that entity who are involved in processing claims and handling my insurance benefits.

Purpose and Condition
The purpose of this disclosure of information is for Rosecrance to obtain authorization and payment for treatment services provided to the client. I understand that treatment is being provided to the client in reliance on obtaining payment for services rendered.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Medical Records Department at Rosecrance. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration and Redisclosure
Unless sooner revoked, this consent expires one year after the last date on which services were provided, or until all claims relating to my treatment are paid in full, whichever is later. State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et seq.).

_____ _____
Signature of Client Date

(Clients ages 12-17 years old are requested to sign and date with co-signature of parent/legal guardian) If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ _____
Name of Parent, Guardian or Personal Representative (Print) Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)._____

_____ _____
Printed Name of Staff / Witness Signature of Staff / Witness Attesting to Identity Date

THIS FORM MEETS ALL REQUIREMENTS OF 42 CFR PART 2, THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT, AND 45 CFR PARTS 160 & 164 (HIPAA)

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ROSECRANCE AND AFFILIATES
Assignment of Benefits / Guarantee of Payment

Client Name: _____ Client ID: _____ Client DOB:_____

Financial Responsibility

I acknowledge and agree:

- That I am financially responsible for all charges for services provided.
- That some or all of the services provided to the client by Rosecrance may not be covered by insurance.
- That services and treatment may be provided by a clinician who is not credentialed or approved by my insurance company but under the supervision of a clinician who is credentialed or approved by my insurance company.
- That I am responsible for all charges for services provided to the client listed above which are not covered by insurance or that are required under my Insurance Plan, such as co-payments or deductibles.
- That Rosecrance may be in-network or out-of-network and I will be responsible for additional charges not covered by policy.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Rosecrance.
- That Rosecrance will verify benefits prior to starting treatment and will share the information with me, but this does not guarantee payment. My insurance company's failure to process claims according to the verification of benefits information provided does not indicate an error by Rosecrance.
- That misrepresentation of insurance information may make me legally responsible for payment to Rosecrance.
- That I am responsible for keeping my insurance information up to date.

_____ _____

Name of Financially Responsible Person | Signature of Financially Responsible Person | Date

Assignment of Benefits

In exchange for and consideration of services provided by Rosecrance to the client listed above and to provide timely and accurate payment for such services:

- I certify that the information given by me for purposes of payment for the client's treatment at Rosecrance is, to the best of my knowledge, **complete and accurate and that no other coverage or insurance exists**.
- I assign my right to receive payment of authorized benefits to Rosecrance.
- I also assign and convey to Rosecrance all rights, powers, authority, and standing to pursue amounts owed under my health insurance plan and to pursue vindication of my rights under my health insurance plan or federal or state law incurred as a result of the treatment I receive from Rosecrance (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal or administrative claims.
- I authorize Rosecrance to file an appeal on my behalf for any denial of payment or adverse benefit determination.
- If my Insurance Plan will not direct payment to Rosecrance, I agree to endorse and forward to Rosecrance all health insurance payments, which I receive for the services rendered by Rosecrance and its health care providers and I agree that I am personally liable to Rosecrance for such monies.
- I understand that Rosecrance would not have accepted the undersigned as a patient, except for this assignment and guarantee of payment.
- If my current health insurance plan prohibits assignment of benefits, I hereby instruct my plan to provide documentation demonstrating such non-assignability to myself and Rosecrance. Failure to provide such documentation within thirty days of receipt of the claim submission shall constitute consent to and assignment and/or knowing and intentional waiver of any non-assignability clause by the plan. Acceptance of a claim submission from Rosecrance, or issuance directly to Rosecrance of an explanation of benefits, remittance advice, determination letter, or other decisional communication concerning the claim, shall be deemed to be consent to assignment or waiver of any non-assignability clause by the plan, its fiduciaries, and/or its third-party administrators.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I intend by this assignment and designation of authorized representative to convey to Rosecrance all my rights to claim the benefits related to services provided by Rosecrance, including rights to any settlement, insurance, or applicable legal or administrative remedies (including claims brought pursuant to state law, federal law or the provisions of ERISA, whether such claims seek benefits,

statutory penalties, or prospective, retrospective, monetary, legal, equitable, or other relief, including without limitation claims for breach of fiduciary duty or claims related to the Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act") or any state law equivalent of the Parity Act). Rosecrance is given the right by me (1) to obtain information regarding the claim to the same extent as me including the summary plan description, certificate of coverage, or other document setting forth the terms of the plan or under which the plan is operated; (2) to submit evidence; (3) to make statements about facts or law; (4) to make any request, including providing or receiving notice of appeal proceedings; (5) to participate in any administrative and judicial actions and to pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. As my assignee and my designated authorized representative, Rosecrance may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. I instruct Rosecrance to use whatever funds may be recovered as a result of actions brought on my behalf to reduce or eliminate any debt I may owe to Rosecrance and any related debt owed by Rosecrance for expenses incurred whilst seeking full reimbursement from my insurer, employer benefit plan, or third-party administrator.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

_____	_____
Name of Client/Parent/Guardian	Signature of Client/Parent/Guardian Date

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ROSECRANCE AND AFFILIATES
CONSENT FOR TREATMENT

Client Name: _____ Client ID: _____ Client DOB: _____

CONSENT TO TREATMENT

I consent to care and treatment by Rosecrance, Inc., its affiliates, and its employees. I also consent to treatment and care by physicians, behavioral health providers, and healthcare providers who are not employees or agents of Rosecrance, but are authorized by Rosecrance to provide treatment and care to me ("Rosecrance Providers"). I understand that my care team at Rosecrance may include resident physicians and students or other trainees.

I understand that my treatment and care will include mental health or substance use disorder treatment, including but not limited to group, individual, and family counseling; family program; educational lectures; recreational and art activities; and AA/NA/CA meetings. I understand that Rosecrance is an integrated behavioral health system with multiple treatment programs. By signing this form, I understand I am consenting to treatment in any program recommended by my Rosecrance providers.

I acknowledge that the specific benefits and risks of treatment; factors influencing the likelihood of success; treatment alternatives; and my right to refuse treatment services have been explained to me. I acknowledge that sufficient information and explanation concerning the nature and purpose of Rosecrance treatment programs, the procedures, and methods of treatment have been explained to me in order for me to make an informed judgment about my treatment. I am aware that mental health and substance use disorder treatment is not an exact science, and I acknowledge that no one has made any guarantees about the results of my treatment.

CONSENT TO TELEHEALTH SERVICES

I consent to receive treatment and services through telehealth, including through interactive video or audio platforms. I understand that some communication platforms may not be secure, but are allowed under emergency rules. I consent to receiving services via telehealth which may have some risks, including unsecure or unencrypted transmission; audio and video interruptions; access by unauthorized persons; or unexpected disruptions or distortions from technical failures. Although it is unlikely, I understand my protected health information may be breached if someone tampers with the technology. This consent will remain in effect until revoked. I understand that I have the right to revoke my consent at any time by notifying my provider. I understand any technology or data charges incurred while downloading or using telehealth services will be my responsibility. I understand that I may not record any telehealth services without written permission.

INDEPENDENT PHYSICIANS

I have been informed and understand that most physicians providing services at Rosecrance are not employees, agents or apparent agents of Rosecrance, but instead are independent medical practitioners who are responsible for their own judgment or conduct. These independent medical practitioners are not employees of Rosecrance and Rosecrance is not responsible for their actions. A list of physicians who are independent medical practitioners will be provided upon request.

VOLUNTARY NATURE OF PROGRAM

I voluntarily consent to treatment at Rosecrance and that the success of my treatment rests in my willingness to cooperate with the treatment process. I acknowledge that I may leave treatment at any time. I hereby release Rosecrance from all responsibility for any acts or consequences, medical or otherwise, which may result from my leaving treatment without authorization.

ROSECRANCE RULES

Upon admission, I received a Treatment Guide. I agree to cooperate and abide by all Rosecrance Rules contained in the Treatment Guide. I understand that Rosecrance may terminate services if I fail to engage in services, if I do not attend scheduled appointments, if I do not follow treatment recommendations, or if I fail to comply with all rules in the Treatment Guide. I understand that, upon admission to Rosecrance residential services and from time-to-time thereafter, my person and property will be searched for contraband. While in treatment, all alcohol, drugs, medications without appropriate prescription, or drug paraphernalia in my possession and/or brought onto Rosecrance property will be destroyed.

CLIENT RIGHTS AND CONFIDENTIALITY

I have had my client rights and responsibilities explained to me. I have been given a copy of and clearly understand the statement that describes the rights I have in treatment. I understand that my treatment at Rosecrance is subject to strict federal and state confidentiality laws.

During the program, such as in group sessions, I may learn confidential information about other clients in treatment. I agree to keep all information about other clients, including their participation in the program, in the strictest confidence.

PERSONAL PROPERTY AND ROSECRANCE PROPERTY

I understand that Rosecrance is not responsible for personal property that is lost, stolen, damaged, or left behind. I accept responsibility for any damage or destruction that may occur to Rosecrance property as a result of my behavior while I am a Rosecrance client.

RELEASE OF LIABILITY

I understand that part of my treatment may involve activities including but not limited to: 1) use of fitness/gym equipment, 2) participation in sports and recreational activities, 3) participation in experiential therapies, and 4) transportation by Rosecrance ("Activities"). These Activities involve the risk of accident, personal injury, and property damage. I understand that I can refuse to participate in these Activities. I agree for myself, my heirs, assigns, or representatives to waive, release, and forever discharge Rosecrance, its affiliates, and its employees from and against any and all claims, liabilities, and causes of action, whether foreseeable or unforeseeable should any accident occur involving personal injury or property damage during my participation in treatment.

CONSENT TO VIDEOTAPE / AUDIOTAPE

I understand that some Rosecrance facilities may employ video surveillance equipment for security monitoring purposes. I further understand that it is possible that my image will be captured by that equipment and that such images are protected by state and federal confidentiality laws. I also understand that some of my treatment sessions may be audio taped for internal performance improvement and quality assurance.

I understand that if I am under the age of 18 and leave Rosecrance against medical advice that my photograph may be released to law enforcement authorities.

CONSENT FOR ELECTRONIC COMMUNICATION

I give my consent for Rosecrance to communicate with me electronically via email, voicemail, or text message. I understand and acknowledge that there are risks inherent in the electronic transmission of unencrypted information over the internet or cellular networks and that such communications may be lost, delayed, intercepted, corrupted, or otherwise not delivered. I understand I may revoke this consent in writing to the Medical Records Department at Rosecrance at any time. In the case of a crisis or emergency, email and text message communication is not an appropriate method of reaching Rosecrance staff.

☐ **Yes** ☐ **No**

Appointment Communication Preference: ☐ **Home Phone** ☐ **Cell Phone**

Appointment Reminder Preference: ☐ **Voicemail** ☐ **Text**

AUTHORIZATION FOR MEDICAL AND DENTAL TREATMENT AND FINANCIAL RESPONSIBILITY

I authorize Rosecrance to seek and refer to medical or dental treatment as deemed appropriate and necessary by Rosecrance staff. I understand Rosecrance utilizes third party services for laboratories, pharmacies, and other medical services and these services represent an additional cost that I am responsible for. If I require emergency services while receiving treatment, I will be responsible for any costs charged by third parties who provide these emergency services. Rosecrance is not responsible for the actions and decisions of third party providers.

I certify that I have read the above form, that I understand its contents, and that I have asked all questions I have about this form. I agree to be bound by the terms of this consent form.

_____	_____	_____
Client Name (Please Print)	Client ID#	Client DOB
_____		_____
Client Signature		Date
_____		_____
Parent/Guardian Signature, *if applicable*		Date
_____		_____
Witness Signature		Date

Notice of Privacy Practices

Aspen COUNSELING & Consulting, L.L.C.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected health information" or "PHI" is information about you, including demographic information that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services. The confidentiality of mental health and alcohol and drug abuse client records is specifically protected by state and/or federal law and regulations. Rosecrance, Inc., Rosecrance Health Network, Rosecrance New Life, and Aspen Counseling & Consulting, LLC (collectively the "Covered Entities") are required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the program that you attend/attended the program or disclosing any information that identifies you as a client with a mental health or substance use disorder. If you suspect a violation, you may file a report to the appropriate authorities in accordance with state and federal regulations. Additionally, the covered entities included in this joint notice will share protected health information with each other, as necessary, to carry out treatment, payment and healthcare operations. Rosecrance must legally maintain the privacy and security of your PHI and follow the duties and privacy practices described in this notice. Rosecrance will not use or share information other than as described here unless authorized in writing.

How we may use and disclose health information about you

- **For treatment.** We may use medical and clinical information about you to provide you with treatment or services, coordinating care, or managing your treatment. If you are a substance abuse client, we may disclose PHI to other providers after obtaining your authorization. If you are a mental health client, we may coordinate your care with other providers without authorizations. For example, Rosecrance may need to request a list of your current medications prescribed by your primary care physician.
- **For payment.** With your authorization, we may use and disclose protected health information about you so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.
- **For health care operations.** We may use and disclose your protected health information for certain purposes in connection with the operation of our program, including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.
- **Required by law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the privacy rule.
- **With authorization.** We must obtain written authorization from you for all other uses and disclosures of your PHI.
- **Without authorization.** Applicable law also permits us to disclose information about you without your authorization in a limited number of other situations, such as with a court order. These situations are explained below.
  - **Health oversight.** We may disclose PHI to a health oversight agency for activities authorized by law, such as for audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third party payors) and peer review organizations performing utilization and quality control. If we disclose PHI for substance abuse clients to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your information.

- **Public health.** We may disclose your PHI for public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority. In certain circumstances outlined in the privacy regulations, we may disclose your PHI to a person who is subject to the jurisdiction of the Food and Drug Administration with respect to the reporting of certain occurrences involving food, drugs, or other products distributed by such person. In certain limited circumstances, we may also disclose your PHI to a person that may have been exposed to a communicable disease or may otherwise be at risk of spreading or contracting such disease, if such disease is authorized by law. For example, we may disclose PHI regarding the fact that you have contracted a certain communicable disease to a public health authority authorized by law to collect or receive such information.
- **Fundraising.** Rosecrance may use your protected health information to communicate with you to request a donation for a fundraising effort in support of or on the behalf of Rosecrance. You have the right to opt out of receiving fundraising communications. You can write to the Development Coordinator at 1021 N. Mulford Road, Rockford, Illinois 61107 or email giving@rosecrance.org with your request to opt out of future communications.
- **Program evaluation.** We may use your protected health information to contact you for evaluation and follow-up studies conducted by Rosecrance staff in order to determine effectiveness of Rosecrance services. Rosecrance may also disclose PHI to external program evaluators (including the Secretary of HHS for HIPAA rules, compliance and enforcement purposes), with an agreement in place, if substance abuse records are requested to be sent to or taken with the evaluator.
- **Medical emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only and as legally permissible if you are a substance abuse client. If you are a mental health client, Rosecrance can disclose your information in a medical emergency.
- **Coordination of care.** For mental health clients, Rosecrance staff may disclose PHI for the purposes of continuity of care without consent. The purpose of coordination will be limited to admission, treatment, planning, coordinating care, discharge, or governmentally mandated public health reporting. For substance abuse clients and situations that are not emergencies, authorization is needed to coordinate care with third parties.
- **Mandated Reporting.** We may use your protected health information in order to comply with rules and regulations mandating Rosecrance staff to report to law enforcement or government agencies. Examples of situations where reporting may be necessary include abuse and neglect, FOID reporting to DHS, and duty to warn situations. Duty to warn situations occur when someone indicates a specific act of violence towards themselves or another individual.
- **Deceased client.** We may disclose PHI regarding deceased clients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.
- **Research.** We may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations; and (d) the researchers agree not to redisclose your protected health information except back to Rosecrance.
- **Criminal activity on program premises/against program personnel.** If you are a substance abuse client, we may disclose your PHI to the law enforcement officials if you have committed a crime on program premises or against program personnel or have threatened to do so. If you are a mental health client, your information may be disclosed if Rosecrance believes a violation of criminal law or other serious incident has occurred in Rosecrance program.
- **Legal.** We may disclose your PHI to respond to lawsuits and legal actions. If you are involved in a legal issue where Rosecrance is not a party, Rosecrance may disclose your information with your authorization or court order for situations involving family matters, worker's compensation, civil actions, or other legal issues.
- **Court order.** We may disclose your PHI if the court issues an appropriate order and follows required procedures.
- **Special government functions.** If you are an active military member or veteran, we may disclose your PHI as required by military command authorities. We may disclose your PHI to authorized federal officials for national security and intelligence reasons and to the Department of State for medical suitability determinations.

Notice of Privacy Practices (cont.)

Aspen COUNSELING & Consulting, L.L.C.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to the Aspen Medical Records Department at 8616 Northern Ave, Rockford, IL 61107. If you have any questions, you may contact the privacy officer at 815.391.1000.

- **Right to revocation.** It is your right to revoke any authorizations, at any time by sending written notification to the Medical Records Department to the addresses listed above.
- **Right of access to inspect and copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the privacy officer if you have any questions.
- **Right to an accounting of disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to request restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to request confidential communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a copy of this notice.** You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our privacy officer at 1021 North Mulford Road, Rockford, IL 61107, 815.391.1000. You may also file a complaint with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling 202.619.0257. We will not retaliate against you for filing a complaint.

Confidentiality of alcohol and drug abuse client records

The confidentiality of alcohol and drug abuse client records is protected by additional federal law and regulations. The covered entities are required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the covered entities that you attend a substance abuse treatment program or disclosing any information that identifies you as an individual with a substance use disorder. Some of the exceptions to this general rule include:

- The disclosure is allowed by a court order.
- The disclosure is made to medical personnel in a medical emergency.
- The disclosure is with your written consent.

Notice of Privacy Practices (cont.)

The violation of federal laws or regulations by this program is a crime. If you suspect a violation, you may file a report to the appropriate authorities in accordance with federal regulations.

Confidentiality of mental health client records

The confidentiality of mental health client records is protected by state law and regulations. The covered entities are required to comply with these additional restrictions. This includes a prohibition, with limited exceptions, on informing anyone outside the Covered Entities that you are a recipient of mental health treatment or disclosing any information that identifies you as a mental health client. Some of the exceptions to this general rule include:

- The disclosure is allowed by a court order.
- The disclosure is made to medical personnel in a medical emergency.
- The disclosure is with your written consent.
- The disclosure for purposes of health information exchange, in accordance with the requirements of the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Unless you have chosen to opt-out of the health information exchange as specified in that Act.

The violation of state laws or regulations by this program is a crime. If you suspect a violation you may file a report to the appropriate authorities in accordance with State law.

If you have any questions about this Notice of Privacy Practices, please contact our privacy officer:

Privacy Office
1021 North Mulford Road
Rockford, IL 61107
815.387.5600

This Notice of Privacy Practices describes how we may use and disclose your protected health information ("PHI") in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice of Privacy Practices by posting a copy on our website: www.rosecrance.org, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

The effective date of this notice is August 3, 2016.

Client Name (Print):_____ Client ID #:_____ DOB:_____

Notice of Privacy Practices - Receipt and Acknowledgment of Notice

I acknowledge that I have received and have been given an opportunity to read a copy of Aspen Counseling & Consulting, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact: Aspen's Privacy Officer at 1021 N. Mulford Road, Rockford, IL 61107, at (815) 387-5600, or via email at privacy@rosecrance.org

Client Signature: _____ Date: _____

Parent/ Guardian Signature *(if applicable)*: _____ Date: _____