# NOTICE OF PRIVACY PRACTICES

# AND CLIENT RIGHTS

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 August 13, 2019.

We respect patient/client 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 this Agency. We are obligated under law to protect the privacy of your information, and we are required to honor the terms of this notice.

Human Support Services participates with other behavioral health services agencies (each, a “Participating Covered Entity”) in the IPA Network established by Illinois Health Practice Alliance, LLC (“Company”). Through Company, the Participating Covered Entities have formed one or more organized systems of health care in which the Participating Covered Entities participate in joint quality assurance activities, and/or share financial risk for the delivery of health care with other Participating Covered Entities, and as such qualify to participate in an Organized Health Care Arrangement (“OHCA”), as defined by the Privacy Rule. As OHCA participants, all Participating Covered Entities may share the PHI of their patients for the Treatment, Payment and Health Care Operations purposes of all of the OHCA participants.

Privacy Contact. If you have any questions about this policy or your rights please contact our Corporate Compliance Officer, 618-939-4444 ext. 1242.

## 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 within and outside our agency. This includes releasing information for the purpose of:

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 are consulting with or referring you to. We may disclose your confidential information **without** your consent to the Illinois Department of Human Services for the purpose of admission, treatment, planning and discharge to and from State operated facilities. In order to release your information to any other person or agency for the purpose of admission, treatment, planning and discharge we must obtain your written permission.

Payment. With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes. 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, training staff, and verifying your payment information.

**Information Disclosed Without Your Consent.** Under Illinois and federal law, 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 on your voice mail or leave an email or text message unless you tell us not to.

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 for activities authorized by law, such as audits, investigations inspections and licensure. 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 that fund our services or for coordination of your care.

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. You may also opt out of our providing your contact information for any marketing that results in compensation to the Agency.

## PATIENT RIGHTS

You have the following rights under Illinois and federal law:

Copy of Record. You are entitled to inspect the client record our Agency has generated about you. We may charge you a reasonable fee for copying and mailing your record based on our Right to Review and Request Copiers of Clinical Records Policy and Procedure.

Release of Records. You may consent in writing to release of 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 clinical 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 **Privacy Contact**.

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 be glad to provide you information by email if you request it.

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 **Privacy Contact** and ask for the *Request to Amend Health* Information 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. Please submit your request in writing to our **Privacy Contact**. We will notify you of the cost involved in preparing this list.

Notification of Breach. 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. 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.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our **Privacy Contact** in writing at our office for further information. You also may complain to the Secretary of 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.

CLIENT RIGHTS STATEMENT

This agency is committed to insure that you receive professional and humanistic services directed toward your needs in a manner that protects your dignity and feelings of self-worth. Services will be rendered in a manner that is free of harassment, coercion, and that protects your rights to self-determination. As a client of our Agency you have the following rights:

**CIVIL RIGHTS**

1. You have the right to be treated with dignity and respect and,
2. You retain all rights, benefits, and privileges guaranteed by law.

**DISCRIMINATION**

Services will be provided to you and/or your family members without discrimination. Race, color, creed, religion, national origin, sex, sexual orientation, HIV/AIDS status, age, marital status, disability, financial status or status as a disabled veteran or Vietnam era veteran will not affect our services to you. HSS will be respectful of, and responsive to, cultural and linguistic differences. HSS will be consistent in enforcement of program rules and expectations.

1. You have a right to receive services for which you are qualified. If requested, we will attempt to schedule services in a manner that minimizes your costs due to travel and/or loss of work time. If you are unable to pay for services, you may request to meet with someone that can help you in accesses services through this or another provider. No physical barriers will preclude treatment.
2. Services will be provided with a minimum of waiting time. The agency’s operational hours will be reasonably convenient to all clients requesting services. M-TU-TH 8A-8P, W 8A-4:30P, F 8A-4:30P. Crisis services are available 24 hours a day 7 days per week.

**CONFIDENTIALITY**

1. All information concerning you is held confidential and released only through procedures consistent with the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110/1-17]**,** Health Information Portability and Accountability Act (HIPAA), and professional ethics. Your records can be subpoenaed by the Court without your permission.
2. You have a right to review and approve any information being requested by another provider giving service to you. You must sign a Consent for Release of Information for any such information to be sent.
3. You have a right to the confidentiality of information protected by the AIDS Confidentiality Act and AIDS Code. The following information is protected by the AIDS Confidentiality Act and AIDS Code:

a) a request for an/or signed consent to HIV antibody testing;

b) an individual’s HIV antibody or AIDS status;

c) the fact that an individual has been tested for HIV antibodies, and/ the result of an HIV antibody test; and/or

d) participation is pre-test and/or post-test counseling.

1. Unless disclosure is authorized by statute and rule, no information protected by the AIDS Confidentiality Act and the AIDS Code shall be released by any member of the agency to other staff members and/or any other person unless you sign a consent for the release of the information.

NOTE: You are not required to tell any staff member whether you have been tested for HIV antibodies, and/or the result of any such test.

1. The agency is required by law to report any suspected child abuse and/or neglect.
2. The agency is required by law to report any suspected elder abuse and/or neglect.

**TREATMENT**

1. You have the right to an individual plan for treatment and will be expected to participate in your treatment planning. You may refuse treatment, medication or any specific treatment unless mandated by law or court order and will be informed of the consequences resulting from a refusal of treatment and treatment procedure.

2. You have the right to know the name and professional credentials of anyone working with you.

3. You have the right to be:

a) treated with dignity and respect

b) free from psychological abuse including humiliation, threatening and exploiting action

c) free from physical/verbal abuse

d) free from sexual abuse/harassment

e) free from fiduciary abuse

f) of yourself, your family and or/legal guardians to participate in decisions regarding the services provided

g) to lodge complaints, grievances or appeals

h) be informed of the benefits, risks, side effects, and alternatives to planned services

4.You may review your clinical records upon your written request. A staff member will be assigned to be with you during your record review. If you request a copy of information in your record, you will be charged photocopying fees. Records from other providers will not be released.

5. You have the right to be assigned a case manager who will advocate for you and who will assist you in obtaining services throughout your treatment program.

6. You will be advised of the positive effects and possible complications of any drugs or medication prescribed by any physician involved in your treatment. If medications are prescribed, you have the right to refuse specific medications.

7. Treatment will be provided in the least restricted environment.

8. An adult of sound mind has a right to make a declaration of preferences or instructions regarding mental health treatment as provided in the Mental Health Treatment Preference Declaration Act [755 ILLCS 43/1-75]. A Mental Health Preference Declaration is legal form you can create to give instructions about your mental health treatment, if you can’t make those decisions yourself in the future. You may also name someone as your attorney-in-fact. That person can make your mental health decisions for you, or make sure the treatment instructions you put into your Declaration are followed. If you decide you want a Declaration, you should talk about these decisions with a doctor and with a lawyer.

9. We can provide services to adolescents ages 12-18 up to 8 sessions not to exceed 90 minutes each without parent/guardian consent, after 8 sessions parent/guardian consent is required to provide additional services.

**TERMINATION OF TREATMENT**

A client’s services can be terminated if they no longer meet admission criteria or if their behavior warrants dismissal and the behavior has been discussed with them and they have been given a warning. Examples of behavior that warrant termination of treatment are repeated threats of harm or property damage and/or unwillingness to participate in active resolution of the behavior. All terminations must be discussed with the Clinical Coordinator of the program to which the client belongs. Appropriate referrals to other treatment services will be made.

**GRIEVANCE**

1. If you feel your treatment has not been fair or reasonable, you may present your concerns in writing to the case manager assigned to you or to another employee of the agency without fear of retaliation. You are not required to use any specific form to document your grievance; however, if you request a form one will be provided to you. The clinician will meet with you within 10 working days for your written grievance to attempt to resolve the concerns expressed in your written grievance. If you are not satisfied with the outcome of the grievance hearing with your clinician, you may present your concerns in writing to the Clinical Director. The Clinical Director will meet with you within 10 working days to attempt to resolve the concerns expressed in your written grievance. The Clinical Director will provide at that time written notification of the resolutions and an explanation of any further appeals, rights or recourse ensuring that at least one level of the review does not involve the person about whom the complaint has been made. If you are not satisfied with the outcome of the grievance hearing with the Clinical Director, you may present your concerns in writing to the Executive Director of Human Support Services. The Executive Director will meet with you within 30 days of receipt of your written grievance to try to resolve your concerns. The Executive Director’s decision on the grievance shall constitute a final administrative decision, except when such decision is subject to review by the provider’s governing body, in which case the governing board’s decision is final. All alleged Human Rights Violations will be taken to the Board of Directors. You have the right to have your complaints acted upon.

2. A record of grievance or adverse decision appeal and the response thereto shall be maintained by the provider.

3. You have the right to legal recourse, if you believe you have been treated improperly; you have the right to confer with a family attorney, physician, clergyman, and others at any time.

**AGENCY RESPONSIBILITIES**

In addition to protecting client’s rights, Human Support Services maintains responsibility for:

1. Assigning a therapist, counselor, case manager, and agency provider.

2. Deciding on the mode of treatment.

3. Assigning the frequency and duration of client involvement

4. Involving family members or significant others in treatment when appropriate.

5. Maintaining an accurate clinical record.

6. Making referrals to other service agencies.

7. Billing for services either directly, or through insurance or other third-party payees.

8. Defining criteria for termination of services.

9. Communicating with Courts or responsible officials thereof, as mandated by Statute, Rule, or Court decision.

**PROTECTED RIGHTS**

Human Support Services shall ensure the following rights are protected in accordance with Chapter 2 of THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE.

1. The use of seclusion shall not be permitted.

2. You have the right to remain in treatment unless you voluntarily withdraw or meet criteria for termination.

3. You have the right to contact the Guardianship and Advocacy Commission, Equip for Equality, Inc., Human Rights Authority, Department of Human Services – Office of Mental Health, Department of Public Health**,** and Department of Children and Family Services.

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| Guardianship &Advoc. Advocacy | Equip for Equality, Inc. | Human Rights Authority | Dept.PublicHealth |
| #7 Cottage Drive | 1-800-758-0464 | #7 Cottage Drive | 2309 W. Main |
| Anna, IL 62906 |  | Anna, IL 62906 | Marion, IL 62959 |
| 618-833-4897 |  | 618-833-4897 | 1-800-252-4343 |

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| --- | --- | --- |
| Department of Human Services | DCFS | Office of Inspector General |
| 401 William Stratton Bldg. | Industrial Drive, 108 Denny | 901 Southwind Road |
| Springfield, IL 62765 | Anna, IL 62906 | Springfield, IL 62703 |
| 217-785-6023 | 618-833-4449 | 217-786-0019 |
|  | 800-252-2873 | 800-368-1463 |

4. This information will be given to you or your guardian in a language you understand.

5. Staff advisement of your rights and justification for any restriction of your rights will be

documented in your record.

6. Every individual in treatment shall be free from abuse and neglect.

1. You or your guardian shall be permitted to purchase and use the services of private physicians and other mental health and developmental disabilities professionals of your choice. This shall be documented in your services plan.
2. You shall not be denied, suspended, or terminated from services or have services reduced for exercising any of your rights.

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Consumer Signature (12 years or older) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Parent/Legal Guardian Date

I have explained patient rights to the consumer. I believe that they or their guardian understand their rights.

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Staff Signature

HUMAN SUPPORT SERVICES

CONSENTS AUTHORIZATIONS AND AGREEMENTS

PLEASE SIGN BELOW:

I have agreed upon my fee and find it appropriate.

I have received a copy of the Consumer Manual.

I understand that Human Support Services reserves the right to refuse services to me or to anyone involved with my treatment who comes in for services under the influence of drugs or alcohol.

I authorize Human Support Services to release diagnostic information and date(s) and type(s) of service rendered to the insurance company for the purpose of processing my claim and authorize payment of medical benefits to Human Support Services. I authorize payment to be made directly to Human Support Services for insurance benefits payable to me. I understand that I am financially responsible to Human Support Services 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. 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 Human Support Services. I authorize Human Support Services to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Human Support Services may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

I have provided information as an Application for Service with the understanding that all information is held in the strictest confidence under the Confidentiality Act, HIPAA and HITECH. I have received a copy of “Notice of Privacy Act”. I acknowledge having received Human Support Services’ “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 Human Support Services has already made disclosures with my prior consent.

I hereby consent to counseling, other treatment, and the possible prescription of medication as provided by Human Support Services employees or designees. If consumer is a minor or has been adjudicated disabled, the undersigned parent or legal guardian, hereby consents to counseling, other treatment, and the possible prescription of medication.

I understand that Human Support Services staff are Mandated Reporters and this means they are required by law to report suspected child abuse or elderly abuse.

I have read the Notice of Privacy Practices and Client Rights, or have had it read and explained to me. I understand its contents and have received a copy of it. The signature of the staff person below indicates that they believe I understand the Notice of Privacy Practices and Client Rights.

***Substance Use Clients Only:***

No provider of substance abuse services receiving Federal Funds from the U. S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in the a religious practice. If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the service you would have received from this organization.

As a DUI Court Ordered Evaluation recipient, I, the undersigned, consent to the treatment plan and other procedures explained in the DUI Evaluation Consumer Service Manual. I understand its contents and have received a personal copy. I have received a copy of OASA’s “Notice of Privacy Practices”.

When requesting documents for court appearances, I will notify Substance Abuse department support staff in advance by phone or a written request. I understand that the paperwork will be ready for pick up as follows: Updates will take three business days; a Court Ordered Evaluation, Treatment Verifications and/or Certificate of Completion will take one working day. I understand that there will be no exception to this practice.

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Consumer Signature (12 years or older) Date CIS Identification #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Date

I have explained patient rights to the consumer. I believe that they or their guardian understand their rights.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature