Welcome to the Ecker Center for Mental Health. We hope that we can be of assistance and thank you for choosing the Ecker Center for your mental health needs. The Ecker Center offers a variety of services: residential care, therapy, psychosocial rehabilitation, case management, psychiatry, nursing and 24-hour crisis intervention.

In an effort to help you better utilize your treatment and understand the 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 an assessment process which will include a Comprehensive Mental Health Assessment and may include a Psychiatric Evaluation. 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. 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 regime.

4. Crisis situations can occur between scheduled appointments and the Center has services available 24 hours per day to address this situation. In the event that you experience a crisis, you can go to our Psychiatric Emergency Program (PEP) at Advocate Sherman Hospital which is located next to the emergency department. Address: 1425 N. Randall Rd, Elgin, IL 60123. Phone number: 847-888-2211.

5. Regular attendance at appointments is necessary for effective treatment. Please attend all appointments consistently as scheduled. If you must miss an appointment, please let us know 24 hours in advance to avoid fee charges.

6. Ecker Center professionals do not provide depositions, court evaluations or serve as expert witnesses for people who do not utilize the treatment and recovery services of the Ecker Center. In the event that agency personnel are ordered to provide any of the above, there will be a charge for these services.

7. Our telephone number is 847-695-0484. You can reach specific departments by extension.

05/2018

Hope, Recovery and Well Being
Voice 847-695-0484
DEAF HARD OF HEARING: ILLINOIS RELAY CENTER AT 711
FAX: 847-695-1265
www.eckercenter.org

United Way of Elgin
Fox Valley United Way
United Way of Metro Chicago
Welcome to the Ecker Center for Mental Health. The first step in treatment is completing Intake. Once Intake is completed, a Mental Health Assessment will be conducted to gather information along with your input to assist staff with determining services that you may need at Ecker. **Please fill-out this form in its entirety.**

**DEMOGRAPHIC INFO**

**Guardian Status:**
- [ ] Own Guardian
- [ ] Biological Parent
- [ ] Adoptive Parent
- [ ] Youth In Care
- [ ] Other Court Appointed
- [ ] Other: 

**Guardian's Information:**
- Name: ____________________________ Relationship: _________
- Phone Number: __________ Address: ___________________________ City: __________
- State: _______ Zip Code: ________ County: _________________

**Emergency Contact Info:**
- [ ] Check if same as Guardian
- Name: ____________________________ Relationship: _________
- Phone Number: __________ Address: ___________________________ City: __________
- State: _______ Zip Code: ________

**Members of the Household:**
- Name: ____________________________ Age: ______ Relationship: _________
- Name: ____________________________ Age: ______ Relationship: _________
- Name: ____________________________ Age: ______ Relationship: _________
- Name: ____________________________ Age: ______ Relationship: _________

**Other Notable Relationships:**
- Name: ____________________________ Age: ______ Relationship: _________
- Name: ____________________________ Age: ______ Relationship: _________
- Name: ____________________________ Age: ______ Relationship: _________

**Established Supports (i.e. Physician, School/Daycare, Counselor/Therapist, Child Welfare Worker, ISC/PAS Agent, Probation Officer, etc.)**

- Name: ____________________________ Relationship: _________
- Phone: __________ Email:

- Name: ____________________________ Relationship: _________
- Phone: __________ Email:

- Name: ____________________________ Relationship: _________
- Phone: __________ Email:

- Name: ____________________________ Relationship: _________
- Phone: __________ Email:

- Name: ____________________________ Relationship: _________
- Phone: __________ Email:

2/2019
Packet for Intake

TREATMENT

What would you like to accomplish from treatment? ________________________________

__________________________________________

What services are being sought out for treatment? (Please check all that apply)

☐ Psychiatry/Nursing ☐ Individual Therapy ☐ Case Management ☐ MRT Group

☐ PSR Core Program ☐ CST (Community Support Team) ☐ Crisis Residential

☐ Family Counseling ☐ Other (explain): ____________________________

How were you referred to the Ecker Center for Mental Health? (Please check all that apply)

☐ Self ☐ Hospital ☐ School (teacher/counselor) ☐ Shelter: ______

☐ Family ☐ Friend ☐ DHS ☐ Clergy ☐ DCFS ☐ Medical Doctor

☐ Renz Center ☐ Police Dept: ___________ Insurance Company ☐ Court: ______

Other (explain): ____________________________

Have there been any environmental changes recently that have made you seek out treatment? (Please check all that apply)

☐ Loss of home ☐ Divorce/Separation ☐ Legal Problems ☐ Relocation

☐ Loss of a loved one ☐ Loss of insurance ☐ Problems at school/work

☐ Unable to cut down on alcohol/drugs ☐ Other (explain): ________________

Please check the level of difficulty with the following symptoms or behaviors:

Anxiety: (Anxious mood, worry, excessively, panic, shortness of breath, palpitations, sweating)

☐ None ☐ Minor difficulty ☐ More than a little difficulty ☐ Moderate difficulty ☐ Quite a lot of difficulty ☐ Serious difficulty

Manic-like behavior: (Irritability, paranoia, impulsivity, decreased need for sleep, racing thoughts)

☐ None ☐ Minor difficulty ☐ More than a little difficulty ☐ Moderate difficulty ☐ Quite a lot of difficulty ☐ Serious difficulty

Depressive-like behavior: (Depressed mood, tearfulness, crying, fatigue/lack of energy, isolation)

☐ None ☐ Minor difficulty ☐ More than a little difficulty ☐ Moderate difficulty ☐ Quite a lot of difficulty ☐ Serious difficulty

2/2019
Antisocial behavior: (long-term pattern of manipulating, exploiting, or violating the rights of others)

- [ ] None
- [ ] Minor difficulty
- [ ] More than a little difficulty
- [ ] Moderate difficulty
- [ ] Quite a lot of difficulty
- [ ] Serious difficulty

Hallucination: (where someone sees, hears, smells, tastes or feels things that don’t exist outside their mind)

- [ ] None
- [ ] Minor difficulty
- [ ] More than a little difficulty
- [ ] Moderate difficulty
- [ ] Quite a lot of difficulty
- [ ] Serious difficulty

Delusions: (A persistent false psychotic belief regarding the self or persons or objects outside the self that is maintained despite indisputable evidence to the contrary “someone is out to hurt you”)

- [ ] None
- [ ] Minor difficulty
- [ ] More than a little difficulty
- [ ] Moderate difficulty
- [ ] Quite a lot of difficulty
- [ ] Serious difficulty

Current/recent suicidal thoughts? _____ yes _____ no
Current/recent homicidal thoughts? _____ yes _____ no
Current/recent self-injurious behaviors? _____ yes _____ no

**Physical Health**

How would you rate current health status?  
- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

Do any of the following medical conditions apply *(Please check appropriate box)*:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne (severe)</td>
<td></td>
<td></td>
<td></td>
<td>Fibromyalgia</td>
<td></td>
<td></td>
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<tr>
<td>Arthritis</td>
<td></td>
<td></td>
<td></td>
<td>Gastric or Intestinal Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td>Head Trauma/Injury</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Autism/Aspergers</td>
<td></td>
<td></td>
<td></td>
<td>Hearing Problems</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Hepatitis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cardiovascular Disease</td>
<td></td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
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<tr>
<td>Cerebral Palsy</td>
<td></td>
<td></td>
<td></td>
<td>Kidney Disease</td>
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<tr>
<td>Chronic ear infections</td>
<td></td>
<td></td>
<td></td>
<td>Liver Disease</td>
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<tr>
<td>Chronic Insomnia</td>
<td></td>
<td></td>
<td></td>
<td>Migraines</td>
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<tr>
<td>Chronic Pain</td>
<td></td>
<td></td>
<td></td>
<td>Speech Problems</td>
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<tr>
<td>Diabetes</td>
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<td></td>
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<td>Thyroid Disease</td>
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<tr>
<td>Eczema (severe)</td>
<td></td>
<td></td>
<td></td>
<td>Tuberculosis</td>
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<tr>
<td>Emphysema/COPD</td>
<td></td>
<td></td>
<td></td>
<td>Urinary/Bladder Infections</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td></td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
**NUTRITION**

<table>
<thead>
<tr>
<th>Question</th>
<th>(0)</th>
<th>(1)</th>
<th>(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many meals do you eat per day?</td>
<td>3 or more</td>
<td>2 meals</td>
<td>Less than 2</td>
</tr>
<tr>
<td>How many fruits, vegetables, or milk products do you eat per day?</td>
<td>many</td>
<td>few</td>
<td>none</td>
</tr>
<tr>
<td>On average, how many alcoholic drinks do you have per day?</td>
<td>none</td>
<td>1-2</td>
<td>3 or more</td>
</tr>
<tr>
<td>Do you have tooth or mouth problems that make it hard to eat?</td>
<td>no</td>
<td>----</td>
<td>yes</td>
</tr>
<tr>
<td>How many prescription medications do you take per day?</td>
<td>none</td>
<td>1-2</td>
<td>3 or more</td>
</tr>
<tr>
<td>Has a medical condition or illness changed the way you eat?</td>
<td>no</td>
<td>yes</td>
<td>----</td>
</tr>
<tr>
<td>Have you lost or gained 10 pounds or more in the last 4 months without wanting to?</td>
<td>no</td>
<td>----</td>
<td>yes</td>
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<tr>
<td>Do you have a history of an eating disorder?</td>
<td>no</td>
<td>----</td>
<td>yes</td>
</tr>
</tbody>
</table>

Do you have difficulty with:  
- [ ] Swallowing  
- [ ] Chewing  
- [ ] Indigestion  
- [ ] Heartburn  
- [ ] Vomiting  
- [ ] Diarrhea  
- [ ] Constipation  
- [ ] No difficulty with any of these

**OFFICE USE ONLY:**

**Nutritional Risk Score = _____**

If client scores 9 points or more, reports difficulty with eating or digestion, or reports nutritional issues, please refer to Primary Care Physician or local FQHC.

Client was referred to  
- [ ] Primary Care Physician  
- [ ] local FQHC  
- [ ] Other  
- [ ] None needed
CONSUMER CRISIS CARE PLAN

Emergency Contact:  
Phone #  
Primary Physician:  
Dr.  
Phone #  

Support Individual:  
Phone #  
Pharmacy:  
Phone #  

Psychiatric Emergency Program  
Sherman Hospital  
847-888-2211  
Insurance:  
Phone #  

Psychiatrist:  
Dr.  
847-695-0484  
Insurance:  
Phone #  

Ecker Center for Mental Health  

Please list any medications (prescriptions, over-the-counter, herbal) or vitamins that are currently prescribed:

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>PRESCRIBER</th>
<th>DOSE</th>
<th>START DATE</th>
<th>END DATE</th>
<th>REASON</th>
</tr>
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</table>

Any known adverse reactions or allergies to drugs or food?  ☐ Yes  ☐ No  If yes, please describe:

<table>
<thead>
<tr>
<th>ALLERGY</th>
<th>TYPE OF REACTION</th>
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</tbody>
</table>

To be completed with staff:

ACKNOWLEDGEMENT OF CRISIS CARE PLAN

1. I acknowledge with staff the purpose and development of a crisis care plan.
2. I accept a formatted crisis care plan to be utilized in the development of an individualized crisis care plan.

Client Signature: ___________________________  Date: ___________________________
Parent/Guardian: ___________________________  Date: ___________________________
Staff Signature: ___________________________  Date: ___________________________
Packet for Intake

Authorization to Leave Personal Health Information (PHI) by Alternate Means

Current Mailing Address: ________________________________

City: __________________ State: ___________ Zip Code: ___________

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

(Please check all that apply)

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

☐ May leave detailed information with:

Name __________________________
Relationship ___________________

☐ Do not leave any messages. Only speak with me directly at the following phone #:
  Home #: __________________
  Cell #: __________________
  Work #: __________________
  Other #: __________________

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.

To be completed with staff:

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 ___________ Witness 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.)

Signature of Parent or Legal Representative __________________ Date ___________ Relationship __________________________

2/2019
Ecker Center for Mental Health

RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS: You have a right:
1. To maintain all of your legal rights, and be provided mental health services in the least restrictive setting.
2. To individualized service, to participate in treatment planning, and to have access to qualified staff.
3. To request the opinion of a consultant at personal expense and to request a review of your treatment plan.
4. To know the professional status of the staff members responsible for your care.
5. 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.
6. To know the risks, side effects, benefits, and/or experimental nature of treatment procedures.
7. To know the alternative treatment procedures available, to refuse treatment, and to know the consequences for treatment refusal.
8. To know the cost of services rendered.
9. To know if limitations to duration of service 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 agency's management about client care and safety at the agency.
12. To see your clinical record.
13. You have the right to confidentiality as governed by the Confidentiality Act [740 ILCS-110] and Health Insurance Portability Accountability Act, (IL Rev. Stat. 1991, Ch. 91 1/2, par. 2-100 et. Seq.) except:
   a) When because of a mental illness you are reasonably expected to inflict serious harm upon yourself or another in the near future.
   b) When because of a mental illness you are unable to provide for your basic needs or guard yourself from serious harm.
   c) When you are suspected of child abuse.
   d) When you are in need of emergency care.
   e) When such disclosure is necessary to collect sums representing charges for services.
   f) For other reasons as listed in the Mental Health and Developmental Disabilities Code [405 ILCS-5].
14. To not be denied, suspended, or terminated from services, or have services reduced for exercising any of these rights or on the basis of age, sex, race, religious beliefs, ethnic origin, marital status, physical or mental disability, sexual orientation, HIV status, or criminal record.
15. 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.
   The address and telephone numbers are as follows: Guardian and Advocacy Commission is 160 N. LaSalle, Suite S-500, Chicago, IL 60601, 312-793-5900; Protection and Advocacy, Inc. (Equip for Equality) is 11 E. Adams, Chicago, IL 60601, 312-341-0022 or hotline 1-800-537-2632; Department of Human Services is 100 W. Randolph, Suite 6-400, Chicago, IL 60601, 312-814-2753; Department of Corrections is 100 W. Randolph, Suite 4-200, Chicago, IL 60601, 312-814-2955; Department of Children and Family Services is 100 W. Randolph, Suite 6-200, Chicago, IL 60601, 312-814-4650; Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181, 630-792-5000, Illinois Mental Health Collaborative for Access and Choice, P.O.Box 06559, Chicago, IL 60606, 866-359-7953, TTY 866-880-4459.
16. Your rights will be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (IL Rev. Stat. 1991, Ch. 91-1/2 par et. Seq.).
17. The right to have disabilities accommodated as required by the American with Disabilities Act sect. 504 of the Rehabilitation Act & the Human Rights Act [775 ILCS 5].
18. The information shall be explained using language or a method of communication that the client understands & documentation of such explanation shall be placed in the client record.

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. Ask questions if the proposed course of treatment is not understood.
3. Participate in your care by following mutually agreed upon treatment plans.
4. Cooperate and assist in making discharge plans in a responsible and timely manner.
5. Be considerate of other clients in limiting noise, disruption, and in following sanitation and smoking restrictions.
6. Be responsible for the behavior of your minor children brought to the agency.
7. Respect other's property and that of the agency.
8. Refrain from bringing alcohol, illegal drugs, weapons, including concealed firearms, or items intended to be used as weapons on to Ecker premises.
9. Follow written rules and behavior, which are specific to the area or service on which you are being treated.
10. Keep scheduled appointments or cancel them within 24 hours.
11. Arrange for timely payment for services rendered.

I HAVE READ AND RECEIVED THE ABOVE RIGHTS AND RESPONSIBILITIES AND AGREE TO COMPLY WITH THESE POLICIES. STAFF HAS EXPLAINED MY RIGHTS AND I UNDERSTAND THEM.

Client Signature / Guardian Signature / Client ID / Date
Witness

VOICE: 847-695-0484 DEAF / HARD OF HEARING: ILLINOIS RELAY CENTER at 711 FAX: 847-695-1265
http://www.eckercenter.org

05/2018
CLIENT AGREEMENTS, AUTHORIZATIONS, AND INFORMATION

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Ecker Center for Mental Health and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. I understand that there are risks and benefits, possible alternatives, and costs included in treatment.

I understand that I am freely consenting to mental health services at the Ecker Center for Mental Health. I understand that following a mental health assessment, I may be eligible for other services offered at the Ecker Center including crisis intervention, counseling, therapy, case management, vocational assistance, psychosocial rehabilitation, residential support, and psychiatric care, including medication. I have also been given a copy of the client fee policy and understand my responsibilities in this area. My signature on this form signifies that all the above information is correct.

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, or, if I reside in Hanover Township, the Hanover Township Mental Health Board that provides funding to support Ecker Center services.

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.

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
The Ecker Center for Mental Health accepts Medicare assignment for covered services. Medicare reimbursable services (Medication Monitoring, Psychiatric Evaluation & Re-Evaluation, Mental Health Assessment & Re-Assessment, Treatment Planning, Crisis Intervention, Individual and/or Group Therapy) must be provided by a Physician, Advanced Practice Nurse, or Licensed Clinical Social Worker (LCSW). All other services including but not limited to therapy provided by anyone other than a Licensed Clinical Social Worker, PSR (Psychosocial Rehabilitation), Community Support, and Care Management services are not covered by Medicare. 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 Mental Health for any services furnished by the Ecker Center for Mental 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 Item 9 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 Mental 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.

CLIENT SIGNATURE ___________________________ DATE ______________

AGREEMENT RELATED TO CIVIL LITIGATION
The Ecker Center for Mental Health was established in 1955 to provide treatment and recovery services to persons with mental illnesses, especially those with severe and chronic illnesses. The Ecker Center provides these services, with limited State and community funding. This funding is given to the Ecker Center solely for the purpose of providing treatment and recovery resources to persons with mental illness. Therefore, we ask you not to request the Ecker Center’s services providers to become involved as expert witnesses in 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 mental illnesses and not to provide expert witnesses in litigation.
Date:       Client Name:   ID#: X X X

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.

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 Mental 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:

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. 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 Appointment/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 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. 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 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 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 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 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 and after April 14, 2003, 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 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 Privacy Contact 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.

06-2018
Notification of Primary Physician Form

Pursuant to Illinois law, you are being informed that it is desirable that you confer with your primary care physician, regarding your mental health needs. If you have a primary care physician, I am required by law to notify him/her that you are seeking or receiving mental 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 mental 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 mental health services, and I direct you, NOT to notify him/her.

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

Date ____________________________  Client signature

Parent or guardian signature

Witness

Information Sent:  ____ Yes  ____ No

Notification of Primary Physician of Patient Receiving Mental Health Services

Pursuant to Illinois law requiring that License Clinical Professional Counselors and Licensed Clinical Social Workers to inform their patients' primary care physician that the patient is seeking or receiving mental health services, you are hereby notified that

is seeking or receiving such services from me at Ecker Center for Mental Health. The patient has signed a Release of Information Form, a copy of which I am enclosing for your records. I look forward to the opportunity to confer with you about this patient as the occasion or need arises.

Ecker Center Clinician

Phone

REVISED: NO 04/01/03