Date: _____

Client's Name: _____

Upward Community
Mozes & Helen Stern Counseling Center

Parent Assessment

Presenting Problem:

What is the primary reason you are requesting counseling services for your child? What are you most concerned about at the present time?

_____
_____
_____
_____
_____
_____

When did this (problem) begin?

_____

Are there any other significant events that contribute to this or other issues your child is dealing with?

_____
_____
_____

_____
_____

Has anyone else expressed concern about your child? (Ie: Teachers, extended family, friends, etc.)

_____
_____
_____
_____
_____
_____

Family History

Parents married, divorced or separated?

_____

Mother's Name:

_____

Description of relationship with your child: (Good, Fair, Poor)

_____

_____

Father's Name:

_____

Description of relationship with your child: (Good, Fair, Poor)

_____

_____

*Step-parent's name:

_____

Description of relationship with your child: (Good, Fair, Poor)

_____

_____

_

Please list names of siblings, their ages, and quality of relationship (good, fair, poor):

Name	Age	Quality of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Optional) Family's religious status:

Orthodox _____ Conservative _____ Reform _____

Non-Affiliated _____ Other Religion_____

What are some of your family stressors (marital, financial, medical, extended family, etc.)?

_____

_____

_____

_____

Is there anyone in the home that you believe to be abusive (sexually, physically, verbally, financially and/or emotionally)?

_____

_____

_____

_____

_Do you believe that your child has been or is being abused (sexually, physically, verbally, financially and/or emotionally)?

_____

_____

_____

_____

Is there anyone in the home whose addictive behaviors (ie: substance, alcohol, illegal presciption drugs, pornography, etc.) impact your child?

_____

_____

_____

_____

_____

Are there any ongoing legal issues that are impacting your child?

_____

_____

_____

_

Has there been DCFS involvement in your family at any point?

_____

_____

_____

Child's Developmental History (ages 0-5):

Problems experienced during pregnancy and delivery?

_____

Birth complications or problems?

_____

Difficulty bonding?

_____

Early childhood medical/health problems?

_____

_____

_

Did your child receive any therapeutic services during preschool? (OT, PT, Speech, Social skill etc.)

_____

_____

_____

_____

_

Child's Current Health/Medical Information

Primary Care Physician:

_____

Conditions currently being treated:

_____

_

Circle all that apply to your child and provide basic details.

Allergy

_____

Sleep concerns (ie: oversleeping or insomnia)

_____

Eating/weight concerns

_____

Tobacco use

_____

Substance use

_____

Other addictive behaviors

_____

Child's Mental Health:

Does your child typically express feelings of (*check all that apply*):

Sadness/Depression ____
Anxiety ____
Fear ____
Stress/Overwhelm ____
Anger ____
Hopelessness ____
Guilt ____
Remorse ____
Other (please list):
_____
_____
_____

How would you describe your child's personality (*check all that apply*)?

Intense ____
Passive ____
Motivated ____
Engaged ____
Cooperative ____
Sensitive ____
Agreeable ____
Likeable ____
Self-Defeating ____
Argumentative ____
Confident ____
Hopeful ____
Friendly ____
Withdrawn ____
Reserved ____
Indifferent ____
Helpful ____
Other: ____

In the past, has your child attended out-patient therapy? If yes, when and with whom?

_____

_____

_____

Currently, is your child in any form of psychotherapy? If yes, where?

_____

_____

_____

Has your child ever attended a daily partial hospitalization program (PHP)?

_____

_____

Has your child ever been hospitalized for psychiatric treatment?

_____

_____

Medications (*psychotropic*):

Past:

Dates	Type	Dosage	Prescribing Doctor

Present:

Dates	Type	Dosage	Prescribing Doctor

Please identify the treatment goals that you have for your child:

_____

_____

_____

_____

Educational History:

Highest grade level achieved: _____

Learning difficulty/disability?

_____

Does your child have any school related behavioral struggles? If yes, please explain.

_____

_____

_____

School History:

School	**Grades**	**Years**

Social-Emotional History

What are your child's strengths, positive traits, and talents?

_____

_____

_____

_____

How does your child spend their free time?

_____

_____

_____

Describe strengths and gaps in your child's social skills and friendships?

_____

_____

_____

_____

Who are the other significant people in your child's life that are supportive of his or her growth?

_____

_____

_____

Is there anything else your child's therapist should know that doesn't appear on this form?

_____

_____

_____

_____

_____

_____

UPWARD COMMUNITY

Raising Our Future

Client Grievance Procedure

The following is a statement of the Agency's Client Grievance Procedure, and officially notifies

_____ of this procedure.
Client(s)

Upward Community anticipates that conflicts may arise in the course of providing services to our clients. When such conflicts arise, you should talk with the person directly with whom you have a problem to seek a reasonable solution. If you cannot resolve the issue(s) in this manner, you are encouraged to make an appointment with the Supervisor of the person with whom you have a conflict to address the problem.

You may register the complaint or grievance about the services you have received at Upward Community at any time. You should address a letter to the Supervisor of the person with whom you have a conflict stating the nature of the problem or incident resulting in the complaint or grievance including any relevant facts and efforts to resolve the matter. The Supervisor will attend to your complaint or grievance and return a written response to you within five (5) working days outlining Upward Community's response to your grievance.

I have read, understand and received the above Client Grievance Procedure.

_____ _____

(Signature of client – adult or child over 12) Date

_____ _____

(Signature of minor 12-17 years) Date

_____ _____

(Signature of Parent/Legal Guardian) Date

UPWARD COMMUNITY

Raising Our Future

Consent to Services

I/We hereby give my consent to participate in programs offered by Upward Community. I/We understand that this consent is voluntary and I/We may revoke my consent in writing at any time.

I/We understand that the staff of Upward Community periodically conducts program studies to evaluate programs within the Agency. I/We understand and acknowledge that the staff of Upward Community will protect my privacy and maintain confidentiality regarding protected health information about me or any information I/We choose to give in connection with program studies or evaluation.

I/We understand that I/We have the right to inspect any written records disclosed by Upward Community as provided for in the Illinois Confidentiality Act and in the Health Insurance Portability and Accountability Act (HIPPA) of 1996.

I/We understand that my confidential information will be protected by the staff of Upward Community as provided by the Illinois Mental Health and Development Disabilities Confidentiality Act and in the Health Insurance Portability and Accountability Act (HIPPA) of 1996. If my participation in the programs of Madraigos Midwest includes group treatment, I/We agree to honor the confidentiality of other group members.

The right to confidentiality is waived for the following circumstances:

1. Upward Community is required by law to report to the Illinois Department of Children and Family Services any suspected or known case of child abuse and the Department of Aging any suspected or known case of elder abuse.

2. Upward Community is required by law to notify appropriate persons that I/We may be dangerous to myself or to others.

3. Upward Community is required to produce information required by court order.

I/We have been informed of my rights and have had an opportunity to have any questions I/We had answered. I /We understand them and agree with them.

_____ _____

Client Signature Date/Year

_____ _____

Signature of Parent(s)/guardian (must sign if under 18) Date/Year

Print_____ _____

Client Names Date/Year

_____ _____

Upward community Signature Date/Year

UPWARD COMMUNITY

Raising Our Future

This form is optional

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I, _____, hereby authorize ____Upward Community_____ (Client/Parent/Guardian) (Facility/Therapist/Counselor) To: □ Release □ Obtain □ Release and Obtain any record or information regarding

_____

(Client)

The following items must be checked and initialed to be included in the use and/or disclosure of other health information:

□ ____ HIV/AIDS related treatment

□ ____Mental Health Information

□ ____ Psychotherapy notes
□ ____ Sexually transmitted diseases
□ ____ Drug/alcohol diagnosis, treatment/referral.

To_____ _____ (Receiving Agency/person) (Address) For the purpose of: (Please check all that apply)

□ Continuing (health and mental health) treatment or care and continuity of care

□Therapist transition

□Housing and other arrangements and services

□Billing, payment and financial matters and arrangements

□Consultation, advice and representation regarding my condition and needs

□Other _____

This consent is valid until **(calendar date)** _____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not re disclose it without my written authorization.

I also understand that if I refuse to consent to this release of information, the following may occur:

_____

_____

_____

(client under 18) (Signature of adult client or parent if client is under 18) (Date)

_____

(Witness) (Date)

NOTICE TO PATIENT AND RECEVING AGENCY:

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be re-disclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

UPWARD COMMUNITY
Raising Our Future

Card on File Authorization Form

The undersigned agrees and authorizes Upward Community to save the credit card indicated below on file.

Participant's Name: _____

Name as it appears on the Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

3 Digit Code: _____

Mailing Address & Zip Code:

_____

_____

I authorize Upward Community to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Clients may also revoke this form at any time.

Cardholder's Signature and Date:

_____

UPWARD COMMUNITY

Raising Our Future

Financial Agreement

Client Name(s): _____ Date: _____ Clinician_____

Client is: ☐Self –Pay ☐ Insured

Part 1 – Self Pay Information

Type of Action – Check one

☐ New Client ☐ Change/Add Information – enter only information changed A. Send statement

to – If statement should be sent to address other than what is on file fill in below

Name(s)
Address
City State Zip
E-mail

Part 2 – Self Payment

Type of Service	SELF-PAYMENT AMOUNT
Ongoing individual, and/or group counseling (paid per service)	

☐Schedule ☐Adjustment ☐Exception

(must attach form) (must attach form)

Date of 1st Billable Service _____ The fee is retroactive to first

face-to-face session.

TERMS OF PAYMENT

In accordance with the income and expense information I reported to Upward Community, I agree to pay the self-pay amounts set forth above.

- I agree to inform my clinician of changes in my financial situation which may result in a new self pay amount. I understand that all self-pay amounts will be reviewed at least annually.

- I understand that I may be charged for sessions canceled without 24 hours prior notice and that my insurance cannot be billed for missed sessions.

- Payment is due at the time of service. Upward Community reserves the right to not schedule to next session if the payment is not met.

- I agree to pay for each service at the time of check-in unless credit arrangements have been approved beforehand. Payments may be made by cash, check, money order or credit card (Master-Card, Visa or Discover). I understand that if payment is not made on a regular basis, services may be discontinued.

- I understand that the Upward Community subsidizes the difference between the full payment for services delivered and monies collected from clients insurance.

Part 3 – INSURANCE/OTHER

ROLES AND RESPONSIBILITIES

- We will facilitate the utilization of your insurance benefits by performing benefit verification, submitting your claims, and responding to your insurance company's requests for information in a timely manner.

- We are responsible for facilitating any pre-notification, pre-certification, or pre-authorizations if we are informed that it is required.

• We will work with your insurance company to sort out any confusions or questions that may arise. If necessary we will request that you contact your insurance company to assist with the resolution of any problems.

• You are responsible for providing current and complete insurance information. If we do not have a copy of your current insurance ID card we will not bill the insurance company and the client will assume full responsibility for payment.

• We recommend that you verify your benefits and verify that we are an in-network provider under your plan. Our staff will perform a verification of benefits as a courtesy to supplement your own benefit verification. Any "verification" of benefits is NOT a guarantee of coverage.

• Although we do our best to keep track of any maximums allowed per year or per authorization, you are ultimately responsible for tracking any benefit maximums which may pertain to your policy. Any services which exceed these benefit maximums has become client responsibility.

• You are responsible for co-payments, co-insurance and deductibles as specified by your insurance plan as well as any changes which are considered "non-covered" or "excluded" by your insurance including services which are denied for no pre-authorization, pre certification, or pre-notification; or, deemed as not medically necessary.

• You are responsible for being aware of the status of all claims through reviewing correspondence sent by your insurer. This includes claims which are delayed in processing due to circumstances such as review for medical necessity or fulfillment of any administrative requirements. After resolution of the delay, large balances may result for which you are fully responsible.

• If the insurance company sends the check directly to you, payment is expected to be made to Upward Community immediately along with a copy of Explanation of Benefits.

• If your insurance requires a self-referral, you are responsible for complying with your insurance plan's referral requirements.

☐ I have insurance.

☐ I do not have insurance.

☐I have insurance but am not willing to use it for services (A waiver, approved by the Clinical Directors, is required if client has insurance and exception is related to psycho-social issues.

☐Other-Specify_____

Responsible Billing Party Signatures_____ Date_____

Responsible Billing Party Signatures_____ Date_____

Effective Date_____Redetermination Date_____

Clinician Signature and credential_____ Date_____

Supervisor Signature _____ Date_____

When form is completed, copy will be made available for the client.

NOTE: USE SEPARATE TEMPORARY FEE FORM IF UNABLE TO DETERMINE ONGOING FEE AT TIME OF FIRST SERVICE OR REDETERMINATION

UPWARD COMMUNITY

Raising Our Future

Your Privacy Information. Your Privacy Rights. Our Privacy Responsibilities.

This notice is a summary how mental health records and information about you may be used and disclosed, and how you can get access to this information. Your rights are established pursuant to HIPPAA, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, state and federal alcohol and substance abuse privacy laws and the exceptions provided therein. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic mental health record
- Correct your paper or electronic mental health record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we: • We may not disclose any mental health records or information except as provided under HIPPAA, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, state and federal alcohol and substance abuse privacy laws and the exceptions provided therein.

- We may not tell any third party family and friends about your condition except as provided for in the above identified laws. For example: only pursuant to a valid subpoena, release of information, pursuant to the Abused and Neglected Child Reporting Act, and under certain other circumstances of immanent risk of harm.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you

- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address certain workers' compensation, law enforcement, and other government requests and subject to certain conditions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your mental health record
- You can ask to see or get an electronic or paper copy of your mental health record and other health information that we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. • Ask us to correct your mental health record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests. Ask us to limit what we use or share • You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purposed of payment or our operations with your health insurer. We will say s "yes" unless a law requires us to share that information.

• Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we share it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you ask us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

• Get a copy of this privacy notice

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

• Choose someone to act for you.

• If you have given someone mental health power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

• File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on page 1.

• You can file a complaint with U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaintts/.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family

• Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe that it is in your best interest. We may also share

your information when needed to lessen a serious and imminent threat to your health or safety.

Our Uses and Disclosures

How do we typically use or share your health information? Subject to HIPAA, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, state and federal alcohol and substance abuse privacy laws and the exceptions provided therein, we typically use or share your health information in the following ways;

- **Treat you**
- **Run our organization**
- **Bill for your services**
- **We can use and share your health information to bill and get payment from health plans or other entities.**
- **We may contract with business associates to do work directly for us related to your treatment; this may include billing, consultation, legal, and related business practices. In such circumstances, the business associate will be subject to a Business Associates Agreement which obligates any such associate to maintain privacy consistent with the state and federal requirements outlined herein.**

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html, and the Illinois Mental Health and Developmental Disabilities Confidentiality Act, state and federal alcohol and substance abuse privacy laws and the exceptions provided therein.

Subject to certain exceptions, we can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
  - **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- **For more information see:** www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noicepp.html .

Changes to the Terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

- The effective Date of this Notice is _____
- The privacy official (or other privacy contact)
  Fill in Center Address

Email: _____-

- We never market or sell personal information.

I/We have been informed of my rights and have had an opportunity to have any questions I/We had answered. I /We understand them and agree with them.

_____

Client Signature (Adult of Youth 12-17) Date/Year

_____

Client Signature Date/Year

_____

Signature of Parent(s)/guardian (must sign if under 18) Date/Year

UPWARD COMMUNITY

Raising Our Future

AUTHORIZATION TO SUBMIT CLAIMS ASSIGN BENEFITS AND REQUEST AND/OR RELEASE INFORMATION TO HEALTH INSURANCE COMPANIES:

Having been fully informed of the policies and procedures of Upward Community regarding the authorization and/or request for release and re-release of protected health information, as stated, I/we _____ Hereby authorize the following regarding (Client, parent, guardian)

_____
_____. (Client and date(s) of birth)

1. Upward Community submit claims for services provided to me/us to
   _____;
   (Health plan)
2. My health plan named above to release and re-release to Upward Community information regarding insurance benefits or processing claims and Upward Community to release to my health plan named above any medical/social work or other information necessary to process claims and Upward Community to release to my health plan named above any medical/social work or other information necessary to process health insurance claims, which may include diagnosis, type of service, treatment plan, and progress regarding the client named above.

3. Upward Community and my health plan named above to specifically release and re-release drug and alcohol information to each other. (Please initial here: _____)

4. The payment of benefits from my health plan named above to make on my behalf to Upward Community for any services furnished by that supplier.

   I understand that this Information is to be used only for the following: for submitting health insurance claims.
   IN THE EVENT THAT MY INSURANCE COMPANY REIMBURSES ME DIRECTLY, I WILL FORWARD THAT PAYMENT IN ITS ENTIRETY TO UPWARD COMMUNITY. This authorization will be valid until _____, unless I/we revoke it in writing prior to that date.
   (date)

I/we understand that I/we may revoke this consent at any time. I/we understand that this information may be released byUPWARD COMMUNITY. prior to its receipt of any processing of a revocation. I/we may inspect and copy the information to be disclosed.

It has been explained to me/us that a refusal to consent to this release of information will not affect my/our receiving services from Upward Community.

I VERIFY the signature below is mine and may be kept on file.

_____

(Signature of client) (WITNESS) (Date)

_____

(Signature of adult if client is under 18) (WITNESS) (Date)

UPWARD COMMUNITY
Raising Our Future

NOTIFICATION TO CLIENT OF RECOMMENDATION TO INFORM PRIMARY CARE PHYSICIAN OF MENTAL HEALTH SERVICES (FOR CLIENTS WITH INSURANCE):

I, (client, parent, guardian) _____ have been informed, pursuant to Illinois law that is desirable that I discuss with my primary care physician, if I have one, about seeking or receiving mental health services. Unless I waive notification to my primary care physician, Illinois law requires that my physician be notified that I am receiving mental health services. I have been informed that I have the right to waive notification to my primary care physician.

☐ I have indicated my choice by checking off one of the following boxes:

☐ I do not have a primary care physician;
And I do not wish to confer with one. I therefore WAIVE NOTIFICATION to a primary care physician that I am receiving mental health services.

☐ I do have a primary care physician;
However, I do not want him or her to be called. I WAIVE notification to my primary care physician that I am seeking or receiving mental health services, and I direct that you NOT notify him/her.

Please contact my primary care physician.
I AGREE to your notifying my physician that I am seeking or receiving mental health services. My signature below is a Release of information permitting you to notify my physician of this fact. (Release of any content of treatment requires a separate Release is signed specifying the information to be released.)
My primary care physician is:

NAME_____

ADDRESS _____

Signature of client _____ Address_____ Date_____

Signature of Parent/Guardian (If client is under 18) _____
Address_____ Date_____

A SEPARATE RELEASE OF INFORMATION MUST BE SIGNED IF ANY CONTENT OF TREATMENT IS TO BE RELEASED, OR IF ANY ONGOING COMMUNICATION IS TO OCCUR WITH THE PRIMARY CARE PHYSICIAN.

A COPY OF THIS FORM MUST BE RETAINED IN THE RECORD FOR AT LEAST 5 YEARS FROM THE DATE SIGNED.