Anxiety & Stress Center
(708)349-5433

You are asked to read the following material to ensure that you are informed of the nature of your treatment in the offices of the Anxiety & Stress Center and how you will participate in it if you consent to do so. Signing this form will indicate that you have been so informed and that you have given your consent.

CLIENT'S RIGHTS

The following is a description of rights that you, as a client, have regardless of where you may go for treatment. I want you to be fully aware of that you have the right to:

1. Be given the opportunity to decide whether or not to become a client without any pressure by me on your decision.

2. Be informed of the nature and purpose of any assessment or treatment recommended to you by your healthcare provider.

3. Be given an explanation of the procedures to be followed in those assessments or treatments.

4. Be given care for your psychological condition without regard to race, color, religion, national origin, gender identification, or sexual orientation.

5. Be given a description of any discomforts and risks that can be reasonably expected with that care.

6. Be given the opportunity to ask any questions concerning the assessments, treatments and any procedures involved in applying those treatments.

CONFIDENTIALITY

Privacy refers to your right to keep secret anything about yourself that you don't want others to know. **Anonymity** refers to the absence of information that would identify you with any other particular information. **Confidentiality** refers to my responsibility to not disclose to others I know you or I know anything about you. On rare occasions, I am required by law to disclose information about you, and to identify you with it. This exception to the confidentiality rule is legally allowed or necessary in the following circumstances:

- Emergencies
- Suicidal Threats
- Homicidal Threats
- Circumstances Involving Child Abuse or Elder Abuse
- AIDS Diagnosis (HIV infection is not a reportable illness at this time)
- To comply with Firearm Owners Identification (FOID) mandated reporting laws

In addition, you should be aware your insurance company will generally know the nature of your diagnosis and treatment. However, if you choose to pay out-of-pocket for sessions, you have the right to restrict what information is sent to your insurance company or to any third party. In all other cases, I will ask you to sign a "Release of Information," which will allow me to reveal information only to the individuals you indicate on that form. Outside of these requirements, I will not disclose to anyone you are a client without your written permission nor divulge any medical or psychological information about you. Please know your mental health records are kept in a locked location. You have the right to request a copy of your records.

Although extensive precautions are taken to ensure the confidentiality of your information, on extremely rare occasions (such as burglary, theft, or natural disaster), breaches can happen. If a potential breach does occur, my office will investigate the incident to determine if there is a risk to your confidential information. In rare cases, the investigation may suggest a high probability that your confidential information has been compromised. In this instance, I will inform you of (1) the nature of the breach, (2) the types of confidential information involved, (3) steps you can take to protect against potential harm, (4) the steps I have taken to resolve the issue and prevent it from happening again, and (5) my contact information.

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in this Policies and Practices packet to protect the privacy of your health information).

You should be aware that I practice with other mental health professionals and that I may employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice and must follow the guidelines set forth in this document.

I also have contracts with a billing service. As required by HIPAA, I have a formal business associate contract with this business, in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

If you are involved in a court proceeding, and a request is made by another party regarding your diagnosis and treatment, such information is protected by the mental health provider-client privilege law. I cannot disclose any information without a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

If you file a worker's compensation claim, and I am rendering treatment or services in accordance with the provisions of Illinois Workers' Compensation law, I must, upon appropriate request, provide a copy of your record to your employer or their appropriate designee.

Minors and Parents/Guardians

Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 18 cannot examine their child's records unless the child consents and unless I find that there are no compelling reasons for denying the access. Parents are entitled to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Since parental involvement is often crucial to successful treatment, in most cases, I require that clients between 12 and 18 years of age and their parents enter into an agreement that allows parents access to certain additional treatment information. If everyone agrees, during treatment, I will provide parents with general information about the progress of their child's treatment, and his/her/their attendance at scheduled sessions. I will also provide parents with a verbal summary of treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she/they may have.

In the case of a minor, special sensitivity may be required in releasing information about certain topics, such as drugs and sex. I will accept the mental health provider's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

INTAKE PROCEDURES

My goal is to provide comprehensive mental health care for my clients. To determine which treatments would be relevant to my clients' condition, a comprehensive assessment process is used for all new clients. This assessment process evaluates each client psychologically, and typically lasts 1-2 sessions.

Upon completion of this procedure, an individualized, comprehensive, holistic treatment plan will be presented to you. Once psychotherapy begins, I will usually schedule one 45-minute session (one appointment hour of 45-minute duration) per week at a time we agree on, although some sessions may be longer or more frequent. Your treatment plan will help determine how often you will be seen.

NATURE OF YOUR TREATMENT

I provide primary mental health care for my clients. If I determine a specialist for a specific problem would better serve you, you will be referred to a specialist whose expertise will aid in the treatment of that problem.

You should be aware every treatment, whether psychotherapeutic or medical, has associated risks, benefits and alternatives. If these are not made clear to you whenever a treatment recommendation is made, you are welcome to ask all the questions you need in order to decide for yourself to follow through with any proposed procedure. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Once you consent to becoming a client, I will make every effort to ensure your care with me is uninterrupted. If your health coverage is interrupted, I will provide you with assistance in finding other ways in which I can remain as your primary mental health provider. Should our combined efforts fail, I will cooperate fully in transferring your care to the healthcare provider of your choice. If other financial complications arise during the course of your treatment with me, I would like to be apprised of those complications or changes as soon as possible. I may be able to help prevent them from becoming any more problematic than they need to be.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office on a regular basis, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by a voice mail that I monitor frequently. I will make every effort

to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health therapist on call. If I will be unavailable for an extended time, I will provide you with the name of another therapist to contact, if necessary.

RIGHT TO WITHDRAW

You can withdraw being a client of mine at any time. Should you choose to be cared for by another mental health professional, I would like to know of your decision so I may cooperate fully with your choice. Regardless of whether or not you inform me, you will be expected to pay any balance owed, even if you no longer choose me as your mental health provider.

CLIENT RESPONSIBILITIES

All clients have responsibilities that go along with having rights. These responsibilities include:

1. At each office visit, you may be asked about any signs or symptoms that you have experienced that could indicate progression of your distress, or any side effects of treatments you may be receiving. It is important for your safety that you accurately report these symptoms. Additionally, since unusual effects can occur when a person takes several drugs in combination, make sure your medical physician is aware of all other medications, drugs, vitamins, or treatments (including non-traditional therapies) that you may be taking.

2. Once a treatment program is planned for you, it will be your responsibility to be on time to your clinical appointments in order to obtain the best clinical outcome.

3. In the event of an unavoidable scheduling conflict, you are required to **phone me at least 48 hours in advance to cancel your appointment, in order to avoid a cancellation charge.** Please see cancellation and no show policy for more information.

4. We will collaborate with you to set your goals. Please know that we can discuss your progress at any time.

5. We encourage you to bring a calendar, notepad, and pen/pencil to each session and take notes as necessary.

6. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk

about both during our sessions and at home. Please complete all assigned home practice and bring any written home practice assignments to the next session. I will offer telephone assistance on assignments if necessary. If you have not done assigned home practice, please understand that you may be asked to complete it at the beginning of your scheduled treatment time.

7. Repeated absences, repeated failures to complete assignments, medication non-compliance, or any incident of therapy-interfering substance abuse may jeopardize your continued progress in treatment.

8. If I am unavailable, you may contact me and leave a confidential message, which I will return at my earliest convenience. If it is an emergency, you should proceed to the nearest emergency department or call 911.

9. Consult your therapist if you would like to make any changes or additions to this document.

THERAPIST'S RESPONSIBILITIES

1. I will attend all sessions, arriving promptly and ending promptly. In the event of an unavoidable conflict, whenever possible, I will call you at least 24-hours in advance. If a 24-hour notice is not an option, I will contact you as soon as I am reasonably able.

2. I will be available during work hours for assistance should you have questions on out-of-session assigned tasks.

3. I agree to behave in a professional manner and maintain strict compliance with the professional ethics codes specific to my licensure and discipline.

VOLUNTARY CONSENT

I hereby certify I have read the preceding, or that it has been read to me, and I understand its contents. Any questions I have pertaining to my treatment have been and will continue to be answered by my healthcare providers. My signature below means I have freely agreed to participate as a client at the Anxiety & Stress Center at this time.

Client's Signature	Client's Printed Name	Date

Therapist's Signature	Therapist's Printed Name	Date

Guardian's Signature (if client is under 18)	Guardian's Printed Name	Date