

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected health information"(PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. The confidentiality of alcohol and drug abuse Client records is specifically protected by Federal law and regulations. The confidentiality of mental health client records is specifically protected by state law. Nicasa is required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the program that you attend the program or disclosing any information that identifies you as an alcohol or drug abuser. The violation of these laws or regulations by this program is a crime. If you suspect a violation you may file a report to the appropriate authorities in accordance with Federal regulations or applicable law.

How We May Use and Disclose Health Information About You

- **For Services.** We may use medical and clinical information about you to provide you with services.
- **For Payment.** With your authorization, we may use and disclose medical information about you so that we can receive payment for the services provided to you. If you are receiving substance abuse treatment services, this will only be done with your authorization.
- **For Health Care Operations.** We may use and disclose your protected health information ("PHI") for certain purposes in connection with the operation of our program.
- **Without Authorization.** Applicable law also permits us to disclose information about you without your authorization in a limited number of other situations, such as with a court order. These situations are explained on the following pages.
- **With Authorization.** We must obtain written authorization from you for other uses and disclosures of your PHI.

Your Rights Regarding Your PHI. You have the following rights regarding PHI we maintain about you:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted in certain circumstances, to inspect and copy PHI that may be used to make decisions about your care. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.
- **Complaints.** You have the right to file a complaint in writing to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. *We will not retaliate against you for filing a complaint.*

**If you have any questions about this Notice of Privacy Practices,
please contact Nicasa's Privacy Officer at
Nicasa, 31979 Fish Lake Road, Round Lake, IL 60073, (847) 546-6450**

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

How We May Use and Disclose Health Information About You

Listed below are examples of the uses and disclosures that Nicasa may make of your protected health information ("PHI"). These examples are not meant to be exhaustive. Rather, they describe types of uses and disclosures that may be made.

Uses and Disclosures of PHI for Services, Payment and Health Care Operations

Services. Your PHI may be used and disclosed by your physician, counselor, program staff and others outside of our program that are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and any related services. This includes coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care treatment. For example, your protected health information may be provided to the state agency that referred you to our program to ensure that you are participating in treatment. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of the program, becomes involved in your care. Except for emergency services, we will not send your PHI to an outside health care provider who is caring for you unless you give us written authorization to do so.

Payment. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If you are in a substance abuse treatment program, we will not use your PHI to obtain payment for your health care services without your written authorization. If you are in a mental health program, we may use your PHI to obtain payment for your health care services without your written authorization.

Healthcare Operations. We may use or disclose, as needed, your PHI in order to support the business activities of our program including, but not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician or counselor. We may also call you by name in the waiting room when it is time to be seen. We may share your PHI with third parties that perform various business activities (e.g., billing or typing services) for Nicasa, provided we have a written contract with the business that prohibits it from re-disclosing your PHI and requires it to safeguard the privacy of your PHI.

We may contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also contact you concerning Nicasa's fundraising activities.

Other Uses and Disclosures That Do Not Require Your Authorization

Required by Law. We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Health Oversight. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control. If we disclose PHI to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your information.

Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel only. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the initial mandated report.

Deceased Clients. We may disclose PHI regarding deceased Clients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. We may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations; and (d) the researchers agree not to redisclose your protected health information except back to Nicasa.

Criminal Activity on Program Premises/Against Program Personnel. We may disclose your PHI to law enforcement officials if you have committed a crime on program premises or against program personnel.

Court Order. We may disclose your PHI if the court issues an appropriate order and follows required procedures.

Interagency Disclosures. Limited PHI may be disclosed for the purpose of coordinating services among government programs that provide mental health services where those programs have entered into an interagency agreement.

Public Safety. If you are in a mental health treatment program only, we may disclose PHI to avert a serious threat to health or safety, such as physical or mental injury being inflicted on you or someone else.

Uses and Disclosures of PHI With Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization at any time, unless the program or its staff has taken an action in reliance on the authorization of the use or disclosure you permitted.

Your Rights Regarding your Protected Health Information

Your rights with respect to your protected health information are explained below. Any requests with respect to these rights must be in writing. A brief description of how you may exercise these rights is included.

You have the right to inspect and copy your Protected Health Information

You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as we maintain the record. A "designated record set" contains medical and billing records and any other records that the program uses for making decisions about you. Your request must be in writing. We may charge you a reasonable cost-based fee for the copies. We can deny you access to your PHI in certain circumstances. In some of those cases, you will have a right to appeal the denial of access. Please contact our Privacy Officer if you have questions about access to your medical record.

You may have the right to amend your Protected Health Information

You may request, in writing, that we amend your PHI that has been included in a designated record set. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of it. Please contact the Nicasa Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of some types of Protected Health Information disclosures.

You may request an accounting of disclosures for a period of up to six years, excluding disclosures made to you, made for treatment purposes or made as a result of your authorization. We may charge you a reasonable fee if you request more than one accounting in any 12 month period. Please contact our Privacy Officer if you have questions about accounting of disclosures.

You have a right to receive a paper copy of this notice.

You have the right to obtain a copy of this notice from us. Any questions should be directed to our Privacy Officer.

You have the right to request added restrictions on disclosures and uses of your Protected Health Information.

You have the right to ask us not to use or disclose any part of your PHI for treatment, payment or health care operations or to family members involved in your care. Your request for restrictions must be in writing and we are not required to agree to such restrictions. Please contact our Associate Director if you would like to request restrictions on the disclosure of your PHI.

You have a right to request confidential communications.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable, written requests. We may also condition this accommodation by asking you for information regarding how payment will be handled or specification of an alternative address or other method of contact. We will not ask you why you are making the request. Please contact the Client Services Department if you would like to make this request.

Complaints

If you believe we have violated your privacy rights, you may file a complaint in writing to us by notifying Nicasa's Privacy Officer at Nicasa, 31979 Fish Lake Road, Round Lake, IL 60073, (847) 546-6450 . We will not retaliate against you for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services as follows:

200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257

The effective date of this Notice is April 14, 2003.

**Nicasa's Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received a copy of Nicasa's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Nicasa's Privacy Officer at 847-546-6450.

Signature of Client

Date

Signature or Parent, Guardian or Personal Representative *

Date

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

Client Refuses to Acknowledge Receipt:

Signature of Staff Member

Date

**Nicasa
FAC only
Authorization for Services**

I hereby give authorization to Nicasa's Family Advocacy Center Program to provide or locate services and consultation services for myself and my family.

I verify that I am a parent/guardian of a child(ren) under 18 years old who will benefit from these services. (Copy of documentation of this parent/guardian relationship must be attached).

I will commit to participating in Family Stabilization Services which include:

- a) A comprehensive, personalized service plan with goals for my family.
- b) Participation of my children in family meetings and appointments.
- c) Participation in parent education and support classes if recommended.
- d) Weekly contact with my Family Advocacy Counselor for a minimum of 3 to 6 months.
- e) A Service Needs Update with Nicasa 6 months after my first appointment.
- f) Random toxicology screening if deemed necessary by my counselor.
- g) Following all recommendations and referrals made by my Family Advocacy Counselor.

Client Name _____ **Client #:** _____

Client Signature _____ **Date:** _____

Staff Signature _____ **Date:** _____

Nicasa Family Advocacy Customer Satisfaction Survey

We are very interested in what you think about the services that you have received from Nicasa's Family Advocacy Program.

Please tell us how long you received services from the Family Advocacy Program

_____ / _____
(Number of weeks)

The information you provide is strictly confidential and used only to identify improvements in our program services.

For each of the statements below, please circle the number that best represents your experience with Nicasa's Family Advocacy Program.

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
The staff treated me with respect.	1	2	3	4	5
The staff was courteous and helpful on the phone while scheduling appointments.	1	2	3	4	5
The facility was easy to get to.	1	2	3	4	5
The initial assessment and service planning process was sensitive to gender, social, and ethnic issues.	1	2	3	4	5
I actively participated in my service planning.	1	2	3	4	5
Staff took time to explain to me what would happen next throughout my services.	1	2	3	4	5
Overall, I am satisfied with the amount of time my counselor provided me during my time with Nicasa.	1	2	3	4	5
Overall, I feel that the Family Advocacy Services helped me and my family.	1	2	3	4	5
I would recommend this program to my friends and family members who need similar help.	1	2	3	4	5

What did you like about the services you have received from Nicasa's Family Advocacy Program?

What improvements would you suggest for The Family Advocacy Program?



I, _____ (Client's Name), whose date of birth is _____, authorize Nicasa to disclose to and/or obtain from:

(Name of Person/Title of Person or Organization) the following information:

Description of Information to be Disclosed: (Client needs to initial each item to be disclosed)

- | | |
|---|---|
| <input type="checkbox"/> Assessment/Evaluation | <input type="checkbox"/> Risk Reduction Education Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Continuing Recovery Plan |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Treatment Plan/Summary | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Current Treatment Update/Status | <input type="checkbox"/> SOS Documentation (Updates, Tx Verif.) |
| <input type="checkbox"/> Medication Management Info | <input type="checkbox"/> Status/Completion Letters |
| <input type="checkbox"/> Presence/Participation in Tx | <input type="checkbox"/> Other: <u>Open Communication</u> |
| <input type="checkbox"/> Nursing/Medical Information | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Toxicological Reports/Drug Screens | <input type="checkbox"/> Other: _____ |

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to services and when appropriate, coordinate services. If other purpose, please specify: _____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time, by sending written notification to Nicasa at 31979 N. Fish Lake Rd, Round Lake, IL. 60073. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this consent expires one year from the date of my discharge.

Conditions: I further understand that Nicasa will not condition my services on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: *client responsible for obtaining all information in person.*

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et seq.).

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

Signature of Client Date

Signature of Parent, Guardian or Personal Representative Date

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

Check here if client refuses to sign authorization

Signature of Staff Witness Attesting to Identity & Authority Date

EMERGENCY NOTIFICATION

I _____, hereby authorize Nicasa staff to contact the following persons in the case of an emergency.

Primary Contact	

Name	

Phone	
Secondary Contact (to be contacted if primary contact cannot be reached)	

Name	

Phone	

If you have a medical emergency and cannot communicate with First Responders, the following will be shared with emergency personnel:

- Name
- Address
- Date of Birth

Please initial and complete the following if you wish this information to be released to emergency personnel:

_____ All medications that you have disclosed to Nicasa that you are taking.
Initials

_____ The following allergies and/or medical condition(s) _____
Initials

Client Signature

Date

If you are able to communicate, Nicasa will release no private health information to First Responders

Nicasa, NFP

Treatment Agreement – Read carefully, sign, and bring this to your first session

Client Name: _____ Client #: _____

Commitment: You are enrolling in Nicasa's outpatient program. You are expected to participate in all sessions which may include talking about yourself, group exercises and group discussions related to your treatment plan.

Confidentiality: Information discussed in group or with your counselor must be kept confidential. If you see another group member outside of group, avoid discussing group matters. If it is brought to our attention that you have discussed group issues outside of the group, you will be removed from the group.

Behavior: You must be respectful of all others in the facility, including: group members, individuals you may encounter, and all Nicasa staff. Violent, disruptive, or abusive behavior will result in automatic termination from group and may result in termination of all services.

Nicasa is a no smoking (including vaping) campus. If you violate this policy, your counselor will be notified and you will be required to schedule an individual session (1:1) with your counselor. This session is \$50 and you will be charged according to your current co-pay agreement.

After your session starts (group or individual) you will **not** be allowed to exit the building without consent of your counselor. This means you cannot go outside for any reason that has not been approved by your counselor. For sessions greater than 1.5 hours, you will be given a 5 minute break. During this break, you may leave your therapy room to go to the restroom, make a phone call or get a snack. You may **not** use this time to leave the building or to wander the hallways.

You must silence your phone and **put it away** at the beginning of your treatment session. You may only take an **EMERGENCY** call during your session and you will need to let your counselor know the nature of the call.

Attendance : An excused absence is one for which you can provide documentation. Excused absences are limited to death in the family, illness, incarceration, or accident. All other absences are considered unexcused.

If at any time you are **absent from treatment for 30 days**, you will be discharged unsuccessfully, and will need a new admission appointment, or a new evaluation (depending on the amount of time that lapses) before being readmitted to treatment.

Risk Reduction : The full program cost is due at the first session

- If you have an excused absence, YOU need to call and re-schedule the class you missed. You cannot have ANY unexcused absences.
- If you have one unexcused absence, you must schedule, pay for, and attend the entire cycle again. You will not be refunded for the uncompleted balance of the original cycle.
- Subsequent cycle(s) scheduled because of an unexcused absence are not eligible for any fee reduction. You must pay the full program cost, even if you were originally eligible for a reduced fee.

Treatment Group

- If you have two consecutive unexcused absences, you will be removed from the group and must schedule and pay for an individual session with your counselor prior to returning to group.
- You will be charged a \$25.00 fee for any unexcused absence. This fee must be paid before you attend your next group session.
- If you have more than 2 unexcused absences during your treatment you will need to schedule a 1:1 session with your counselor.

Individual Treatment

- If you have two consecutive unexcused absences, your counselor may elect to have you complete another evaluation or have your treatment plan updated to address the reason behind your absences.
- You will be charged a \$25.00 fee for any unexcused absence. This fee must be paid before you attend your next session.

You are currently scheduled for the following (please note times are subject to change based on Agency needs):

Group Schedule:	Risk Reduction	Treatment Group	Treatment Group
Days			
Start date			
Time			

Individual Sessions: Day of Week _____ Time: _____

I fully understand that I am making a commitment to attend and participate in my treatment and consent to comply with all the above rules and policies.

Client Signature

Date

Counselor Signature

Date

Cc: Referral Source: _____