Welcome to Nicasa Services

To better serve you, the Client Accounts Department has developed a list of payment policies. You are asked to follow these policies on attendance and payment procedures.

Attendance
Attendance is taken when you receive you receipt. Before going into your group, you must always stop at the cashier's office and get a receipt, even if you are paid in full. We use this method to count and verify attendance. If you do not get your receipt from the cashier, you will be listed absent. You are required to attend each session. If you are unable to attend a session, you must contact your counselor.

Cancellation Fee/Penalty
If you do not come to a scheduled appointment, a $25 NO SHOW FEE will be added to your account. The scheduled time is held specifically for you, and we require that you cancel 24 hours before your appointment. If you are in a group, contact your counselor as early in the day as possible. If you are having an individual session/appointment, contact the receptionist with your cancellation. Nicasa's phone number is (847) 546-6450.

Risk Reduction Education Sessions
Full payment is required at the first session.

Outpatient Services
Outpatient program costs are charged at each session. You are expected to pay at each session. If you do not pay at each session, you may be discharged from the group and be required to start over. You must pay off your balance before you can start over.

Individual Services
All individual services must be paid at the time of service unless arrangements have been made.

Returned Checks
If a check is returned from the bank, there will be a $30 processing fee added to your account. A cash payment of the balance plus the $30 fee will be required. All services will be suspended until payment is made.

Insurance Reimbursement
Our policy is that you are responsible for payment at the time of service. Please notify Client Accounts if you intend to process insurance. Nicasa will verify benefits and is available to assist you. Please contact the cashier for an insurance questionnaire. Return the completed questionnaire to the cashier.

Thank you for choosing Nicasa.
We will make every effort to answer your questions.

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

TUBERCULOSIS AND HIV/AIDS TESTING SITES

The Illinois Department of Alcoholism and Substance Abuse (DASA) has recommended that all clients being evaluated or treated for alcoholism or other substance abuse related problems be provided with information on local testing and treatment availability.

ALL CLINICS REQUIRE THAT YOU RESIDE IN THE COUNTY THEY SERVE.
You must return to the clinic three days after your test for examination of TB test.

TB TESTING	HIV/AIDS TESTING
Lake County Residents:	
Lake County Tuberculosis Clinic 2415 Dodge Avenue Waukegan, IL 60085 phone: 847/377-8700 hours: $10 or Medicaid Card, No appt. required	Lake County Health Dept. 2400 Belvidere Waukegan, IL 60085 847/360-6500 No charge, by Appointment
Cook County Suburban Residents:	
Cook County Suburban Tuberculosis Clinic 9326 Church Street Des Plaines, IL 80016 phone: 847/297-1090 hours: 11 am – 6:30 pm; Monday 9 am – 4:30 pm Tuesday & Friday cost: No charge, No appt. required	Cook County Dept. of Public Health / Medica Locations in Rolling Meadows, Maywood, Bridgeview, and Markham 708/492-2190 Hours vary No charge, by Appointment
City of Chicago Residents:	
Call Directory Assistance for nearest facility.	
McHenry County Residents:	
McHenry County Tuberculosis Clinic 2200 N. Seminary Avenue Woodstock, IL 60098 phone: 815/338-6675 hours: By appt. only on Monday, Tuesday, Thursday, & Friday cost: $5.00	Communicable Disease / HIV Program 2200 N. Seminary Avenue Woodstock, IL 60098 815/338-6675 M-F No charge, by Appointment
Kenosha County Residents:	
Kenosha County Health Department 714 52nd Street Kenosha, WI 53142 phone: 262/605-6780 hours: 8 – 11:30 am, 1 – 4:30 pm on Monday,Tuesday, Thursday, & Friday cost: $5.00, No appt. required	Kenosha County Health Department 714 52nd Street Kenosha, WI 53142 262/605-6700 or 800/472-8008 No charge, by Appointment

The Lake County Health Department

The clinic offers confidential HIV testing

- Free
- Anonymous
- Monday through Friday by appointment
- Morning, afternoon and early evening
- Call 847/377-5450
- 2400 Belvidere Road, Room 132 in Waukegan

The clinic offers STD testing on a walk-in basis

- Sliding Scale
- Anonymous
- 2400 Belvidere Road – Main Desk
- Tuesday 8:15 a.m. or Thursday 4:00 p.m.
- Limited space

The clinic offers TB testing on a walk-in basis

- $10 – Medicaid Card
- Monday to Friday – 8 to 4
- Call 847/377-8700
- 2415 Dodge Avenue in Waukegan

HIV / AIDS Information

How can you tell who has the virus?

- Only through testing
- People who are infected may look healthy and infect others

How can you get HIV / AIDS?

- Semen or vaginal fluids
- Infected blood
- Sharing infected needles
- Infected mother who transmits it while pregnant, giving birth or breast feeding

How can you avoid it?

- The only 100% way is to abstain or not have sex
- Avoid other people's blood
- Do NOT share needles
- Have available and use latex condoms whenever you have sex
- Do NOT have sex with a person if you don't know their history
- Get tested whenever you change partners
- Have them get tested, also!
- Make sure your partner has been tested
- Become educated about STD / HIV symptoms

Tuberculosis Information

What is Tuberculosis or TB?

- TB is an airborne disease spread when an infected person coughs, sneezes, laughs or sings
- It is a disease spread from person to person that usually affects the lungs
- It can also affect the brain, kidneys or spine
- TB can affect anyone

What are the symptoms of TB?

- Feeling weak or sick
- Weight loss
- Fever
- Night sweats

Who is at a higher risk to get TB?

- People who share breathing space with someone infected with TB
- Poor people
- Homeless people
- People from countries with alot of TB
- Nursing home residents
- Prisoners
- Alcoholics
- Intravenous drug users
- People with medical conditions
- People infected with HIV / AIDS

Nicasa Behavioral Health CLIENT RIGHTS

Nicasa provides treatment for individuals and families. Your rights are protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (405 ILCS 5). Although each of Nicasa's individual programs vary in the type of care offered, the following policies and procedures are made to improve the dignity of all clients and to protect their rights as human beings. These rights will be given to you in all cases.
You have the right:

1. To personalized treatment that is fair, with no unfairness shown because of your race, religion, gender, age, ethnicity, sexual orientation, sexual identity, HIV status, or disability.

2. To have your disabilities accommodated as required by the Americans with Disabilities Act section 504 of the Rehabilitation Act and the Human Rights Act.

3. To be treated at all times with dignity and respect in a setting that is free from the following: physical punishment or abuse; sexual abuse or harassment; psychological abuse including humiliating, threatening and exploitive actions; verbal abuse; neglect; and exploitation for financial gain.

4. To treatment in a setting that is the least interfering to your personal freedom and that provides privacy within the limits of the agency's capabilities.

5. To know that any testing you have regarding HIV/AIDS will be anonymous and that your HIV/AIDS status and testing will remain completely confidential.

6. To know the clinical staff responsible for your care, their credentials, qualifications, and professional experience.

7. To participate in your treatment and discharge planning, including periodic review of your treatment plan.

8. To confidentiality and privacy governed by the Confidentiality Act and the Health Insurance Portability and Accountability of 1996.

9. To confidentiality and privacy and to know that confidentiality is limited by law in cases such as medical emergencies, suspected child abuse, court order, suspected abuse of adults who cannot protect themselves, threats to the lives of others, and any other instances specified by law when disclosure may be made without client's consent.

10. To know that identifiable photographs, video tape, films, etc., will not be made or used without your written consent, nor will you be required to make public statements which acknowledge gratitude to Nicasa, NFP for its services.

11. To complain, initiate a grievance, or report any inappropriate activity without fear of reprisal or retaliation.

    For clients receiving mental health services, clients have the right to:
    a) Contact the Guardianship and Advocacy Commission and Equip for Equality, Inc.
    b) Assistance in contacting these groups, giving each client the address and telephone number of the Guardianship and Advocacy Commission and Equip for Equality,

Inc.: GUARDIANSHIP AND ADVOCACY COMMISSION 160 N. LaSalle Street, Suite S500 Chicago, IL 60601 Voice: (312) 793-5900 or (866) 274-8023 Fax: (312) 793-4311 Website: www.gac.state.il.us.

c) The right or the guardian's right to present grievances up to and including the provider's executive director or comparable position.

d) The right not to be denied, suspended or terminated from services or have services reduced for exercising any rights; and

e) The right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.

12. To give your informed consent, informed refusal, and/or expression of choice (and to be advised of the consequences of your decisions) in regard to service delivery, release of information, the availability of concurrent services, composition of your service delivery team, and your involvement in research projects.

13. To know that Nicasa adheres to all federal and state-required research guidelines and ethics, and to refuse to participate in any research projects without compromising your access to services.

14. To have access and/or referral to legal entities for appropriate representation, as well as access to self-help and advocacy support services.

15. To have access to your record and other information pertinent to your treatment planning, and to have that information released in a timely and appropriate manner that will facilitate decision making. The only exception to this right being the restrictions permitted by federal law (HIPAA) which include psychotherapy notes and information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding.

16. To a prompt investigation and resolution of alleged infringement of these rights.

17. To know that all other legal rights to which you are entitled will be recognized and enforced while you are a client at Nicasa.

18. To request an ethics review/investigation of any staff member without fear of reprisal.

For Residential Clients

19. (For residential clients) To visitation in a suitable area by all concerned persons who have been clinically determined to be of benefit to your treatment in accordance with agency policies.

20. To the receipt and sending of mail without censor and to know that your mail will not be read by staff members.

21. To conduct private telephone conversations in accordance with agency policy unless contraindicated by clinical considerations.

I understand the nature of treatment with Nicasa, and my signature indicates consent to treatment with Nicasa, NFP.

Client Signature: _____ Date: _____

Client's level of understanding: Satisfactory _____ Unsatisfactory _____

I have explained these rights to the individual (or guardian of the individual) and have provided him or her a copy of it. A copy of this form has been filed in the individual's clinical record.

Staff Signature: _____ Date: _____

Duplicate copy of Client Rights statement given to Client's:

Family _____ Significant Other _____ Guardian _____

Nicasa Criminal Justice System Referral

Client#_____

I, _____, whose social security number is _____, hereby consent to communication between Nicasa and:

____ Circuit or District Court of _____ County ordering me to treatment (including the Judge and District Attorney)

____ Illinois Department of Corrections and Parole

____ _____ County Department of Corrections

____ _____ County Department of Probation

____ City of _____ Police Department

____ _____ County Sheriff's Department

____ Treatment Alternatives for Safe Communities ("TASC")

____ Defense Attorney (name): _____

Information will be disclosed for the purpose of informing the criminal justice agencies listed above of my participation and progress in Nicasa programs, including any of the following information: Assessment, Completion Letters, Diagnosis, Treatment Plan or Summary, Current Treatment Update, Medication Management Information, Toxicological Reports/Drug Screens, Educational Information, Discharge/Transfer Summary, Legal History , Other:_____.

I understand that Nicasa is providing treatment to me in reliance on this authorization permitting disclosure to criminal justice agencies. Therefore, I understand that this authorization will remain in effect and cannot be revoked by me until final disposition of the proceeding that gave rise to the criminal justice system referral. At that time, I may revoke this authorization as follows: in writing mailed to Nicasa at 31979 Fish Lake Road, Round Lake, IL 60073. If not revoked, this authorization will terminate one year after the date of discharge or final disposition of the proceeding giving rise to the criminal justice system referral, whichever is later.

A person who receives confidential information may redisclose and use it only to carry out that person's official duties.

_____ _____

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.).

Nicasa

Positive Choices. Lifelong Solutions.

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*)

___ Assessment/Evaluation
___ Diagnosis
___ Psychological Evaluation
___ Psychiatric Evaluation
___ Treatment Plan/Summary
___ Current Treatment Update/Status
___ Medication Management Information
___ Presence/Participation in Treatment
___ Nursing/Medical Information
___ Toxicological Reports/Drug Screens
___ Risk Reduction Education Information
___ Discharge/Transfer Summary
___ Continuing Recovery Plan
___ Progress in Treatment
___ Demographic Information
___ SOS Documentation (Updates, Tx Verification)
___ Status/Completion Letters
___ Other _____
___ Other _____
___ 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 be sending written notification to Nicasa, at 31979 Fish Lake Road, 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

Nicasa Behavioral Health Services
CONSENT FOR SERVICES

I, _____, am choosing to complete the DUI Risk Reduction Education Program. I understand the following admission requirements:

- Provide a copy of my Uniform Report related to the most recent DUI arrest
- Have a DUI classification of Minimal, Moderate, or Significant Risk.
- If I have been found to be in need of this program, but I do not have a Uniform Report (presenting problem is not related to DUI) or my DUI classification is High Risk, I may only attend this program in addition to, not in place of, other recommendations, and I may not utilize state funding to pay for the course.

I understand that I may not attend this program if:

- It is determined I am in need of a higher level of care and/or involvement in education services would not adequately meet my needs.

I understand that the service includes 10 hours over a minimum of 4 different calendar dates lasting no more than 3 hours each, and classroom instruction that will provide a minimum of the following:

1) information on alcohol as a drug;
2) physiological and pharmacological effects of alcohol and other drugs, including their residual impairment on normal levels of driving performance;
3) other drugs, legal and illegal, and their effects on driving when used separately and/or in combination with alcohol;
4) substance abuse/dependence and the effect on individuals and families;
5) blood alcohol concentration (BAC) level and its effect on driving performance;
6) information about Illinois driving under the influence laws and associated penalties;
7) factors that influence the formation of patterns of alcohol and drug abuse; and
8) information about referrals for services that can address any identified problem that may increase the risk for future alcohol/drug related difficulty.

The nature and purpose of the service, the possible complications, the possible alternatives to such services, the risks involved and the possible consequences have been fully explained to me by _____.

I understand that no guarantee or assurance has been given me, by anyone, as to the results of the service. I also have been informed that my records and disclosures will be kept absolutely confidential except only as the law may otherwise require such disclosures. This consent for services is revocable by either party through written notice. In such instances, the case will be closed and maintained for possible future use. After closing the case, the same standards of confidentiality and accessibility to records will be upheld.

_____
Signature of Client

_____
Signature of Witness

_____ _____
Client ID # Date

Nicasa
CONSENT FOR TREATMENT

I authorize and give consent that I, _____, will receive treatment from Nicasa for _____.

The nature and purpose of the therapy, the possible complications, the possible alternatives to such therapy, the risks involved and the possible consequences have been fully explained to me by _____.

I will commit to participating in my treatment including:

- Development of a treatment plan
- Attending individual, group or family sessions, according to the goals developed in my treatment plan
- Random toxicology screenings as deemed necessary by my counselor
- Follow all recommendations and referrals made by/given to me by my counselor
- Particpate in 3 and /or 6 month follow ups after my discharge from the program

I understand that no guarantee or assurance has been given to me, by anyone, as to the results of the therapy.

I also have been informed that my records and disclosures will be kept absolutely confidential except only as the law may otherwise require such disclosures.

This consent for treatment is revocable by either party through written notice. In such instances, the case will be closed and maintained for possible future use. After closing the case, the same standards of confidentiality and accessibility to records will be upheld.

_____
Signature of Client

_____
Signature of Witness

_____
Signature of Parent or Guardian

_____ _____
Client ID# Date

Client Name _____ Client ID#_____

Prescription Drug Policy for Nicasa Treatment Clients

I, _____ Date of Birth, _____ understand the following policy as it relates to the use of prescription drugs while I am in treatment with Nicasa.

- I must immediately inform my counselor of any medication I am taking, whether this medication was obtained through a valid prescription, or through other means.
- I must report to my counselor any change that I have made to my medication regimen, whether I have done this under the direction of my physician or not (ex. Taking more or less than prescribed, taking more or less frequently than directed, ect)
- All clients in treatment for substance use disorder MUST inform their prescriber of this, so that the prescriber can consider this information when making medical decision.
- I will not give medication which has been prescribed to me to anyone else, even if the other person has the same illness I have, or has been prescribed the same medication I am prescribed.
- I will not take a prescription medication that is prescribed to someone else, even if I believe I have the same illness that they are being treated for, and even if I believe I have the same illness that they are being treated for, and even if I have previously been prescribed the same medication.
- I will take my medication as prescribe, and will inform my prescriber if I feel there is a need for any adjustment to my medication regiment.
- Once my physician has determined I am no longer in need of my medication, I will dispose of this medication in accordance with all applicable regulations. I will ask Nicasa staff for assistance locating or utilizing available disposal resources if necessary.
- I will release of information allowing communication between Nicasa staff and the medical staff o any agency (ex. Hospital, clinic, physician's office) that has prescribed me medication that I take at any information will allow Nicasa staff to verify any of the information listed in the above point, or to discuss any other concerns they may have about my use of prescription medication.
- Following the above requirements is crucial to a successful treatment experience. Non-compliance may adversely affect my progress in treatment, will result in my referral source being notified about the concern, and may delay or prevent successful completion of the program.

_____ _____

Client Signature Date

_____ _____

Staff Signature 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 contact 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 at 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.

NODS – DSM-IV – GAMBLING SCREEN

Name: _____ DATE: _____

		Check (✓) YES	NO
1.	Have there ever been periods lasting two weeks or longer when you spent a lot of times thinking about your gambling experiences or planning out future gambling ventures or bets?		
2.	Have there ever been periods lasting two weeks or longer when you spend a lot of time thinking about ways of getting money to gamble with?		
3.	Have there ever been periods when you needed to gamble with increasing amounts of money or with larger bets than before in order to get the same feeling of excitement?		
4.	Have you ever tried to stop, cut down or control your gambling? If "Yes" – go to questions #5. If "No" – go to question #6.		
5.	On one or more of the times when you tried to sop, cut down or control your gambling, were you restless or irritable?		
6.	Have you ever tried but not succeeded in stopping, cutting down or controlling your gambling? If "Yes" – go to questions #7. If "No" – go to question #8.		
7.	Has this happened three or more times?		
8.	Have you ever gambled as a way to escape from personal problems?		
9.	Have you ever gambled to relieve uncomfortable feelings such as guilt, anxiety, helplessness or depression?		
10.	Has there ever been a period when, if you lost money gambling one day, you would return another day to get even?		
11.	Have you ever lied to family members, friends or others about how much you gamble or how much money you lost on gambling? If "Yes" – go to questions #12. If "No" – go to question #13.		
12.	Has this ever happened three or more times?		
13.	Have you ever written a bad check or taken something that did not belong to you from family members or anyone else in order to pay for your gambling?		
14.	Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends?		
15.	ASK ONLY IF CLIENT IS A STUDENT: Has you gambling caused you any problems in school such as missing classes or days of school or your grades have dropped?		
16.	Has your gambling ever caused you to lose a job, have trouble with your job or miss out on an important job or career opportunity?		
17.	Have you ever needed to ask family members or anyone else to loan you money or otherwise bail you out of a desperate money situation that was largely caused by your gambling?		

Do not score items 4, 6, 10

LIFETIME TOTAL SCORE _____

Low-risk Gambler = 0 points
At-risk Gambler = 1-2 points
Problem Gambler = 3-4 points (possible pathological gambler)
Pathological Gambler = 5 or more points

If you are concerned about your gambling, Nicasa can help.
Contact Nicasa today to set up a no-fee consultation appointment.

Nicasa Program Orientation

Client Name: _____ Client #: _____ Date: _____

_____ Client Initials **Your input is important**
Nicasa strives toward improving care for all individuals served. If you have suggestions about how we can do better, please tell your counselor or follow the instructions at www.nicasa.org.

_____ Client Initials **Discharge criteria**
In order to complete your program successfully, you will need to accomplish the following:

- Attend scheduled sessions
- Participate in discussions and assigned work
- Meet your treatment plan goals
- Communicate your needs to your counselor
- Coordinate your care with your therapist or doctor, if applicable

_____ Client Initials **Use of tobacco** - There is no tobacco product use (including e-cigarettes, vaping) inside Nicasa property/vehicle or within 15 feet of any entrance/exit door. No person under the age of 18 may use tobacco on any Nicasa property or vehicle.

_____ Client Initials **Illegal or legal substances brought into the program**
Alcohol, illegal drugs and any intoxicating substances are not allowed on Nicasa property.

_____ Client Initials **Weapons brought into the program**
Nicasa maintains a safe environment. Nicasa prohibits the possession or use of dangerous weapons in Nicasa property to the fullest extent of the law. This includes, but is not limited to, firearms, explosives, knives and other weapons that might be considered dangerous or that could cause harm.

_____ Client Initials **Emergency Response** -

- Emergency exits are marked throughout the building
- Fire Suppression Equipment is available at key points throughout the building
- I am aware Basic first aid kits are located at all Nicasa locations

_____ Client Initials **Complaint and appeal procedure** - Most questions and concerns can be resolved by discussing them with your counselor. However, complaints or grievances can be made to any staff person, or by using the confidential satisfaction survey available at all sites, or the feedback/concerns survey at www.nicasa.org. An initial response will be made within 7 days, for any complaints submitted in writing or electronically, if contact information is provided for such response. A request for a Case Review (regarding an evaluation or current treatment placement) should be submitted in writing to the Director of the location where services were received.

_____ Client Initials **Use of electronics during group sessions** - The use of all electronic devices including cell phones, tablets or any recording device is strictly prohibited at Nicasa during sessions.

_____ Client Initials **Follow-Up** - Nicasa will contact you for follow-up after discharge for a brief survey.

_____ Client Initials **HIPAA Privacy Practices** – I have reviewed 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.

_____ Client Initials **Client Rights** - I have received a copy of Nicasa's Client Rights. I understand the nature of treatment with Nicasa and my initials indicate consent to treatment with Nicasa.

_____ Client Initials **Toxicology Testing Agreement** – I understand that I may be asked to submit to toxicology testing randomly; that test results will be shared with my referral source with my written release; that positive test results may alter my recommended treatment; that I have the right to refuse testing and be informed of the potential consequences of refusing; that I may request a sample be sent for re-test if I dispute the results and that this re-test would be at my expense if confirmed positive.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Thank you for choosing Nicasa.

Nicasa Request for Confidential Means of Communications

☐ ORIGINAL ☐ CHANGE

Today's Date: _____

_____ _____
Client's Name: **Client #**

_____ _____-_____-_____
Client's Birth Date **Social Security Number**

_____
Client's Address:

_____ _____
Daytime Telephone **Evening Telephone**

Nicasa may contact you by mail, phone or fax. This communication may include your protected health information. If you do not wish to be contacted by one or more of these methods please specify below:

DO NOT CONTACT ME AS FOLLOWS: _____

If you wish to be contacted at an address other than the one stated above, please specify below:
PLEASE CONTACT ME AT: _____

If the restrictions affect my payment arrangements, payment will be made as follows:

_____

I understand that Nicasa will agree to all reasonable requests, but may deny a request if I do not clearly provide an alternative means of contact, or if I do not provide information as to how payment, if applicable, will be made. Nicasa will notify me in writing of its response to my request.

_____ _____
Signature of Client **Date**

_____ _____
Signature of Client's Personal Representative **Date**

THIS SECTION TO BE COMPLETED FOR CHANGE IN CONFIDENTIAL MEANS OF COMMUNICATION ONLY

For Organization Use Only:

Date Request Received: _____

Date of Written Response: _____

Action taken (CHECK ONE): _____ **Approved** _____ **Denied**

_____ _____
Staff person signature **Date**

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 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: _____

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PRIORITY POPULATION SCREENING

The following population of clients will be given priority when entering treatment. Check off all that apply:

	YES	NO
• Pregnant Intravenous Drug Users (IDU's)	☐	☐
• Pregnant and postpartum substance abusers	☐	☐
• IDU's	☐	☐
• TANF eligible	☐	☐
• DCFS patients	☐	☐
• Women and youth	☐	☐
• DOC releases who have completed a prison treatment program	☐	☐
• TASC referrals	☐	☐

Any client within these specified populations will be immediately registered into treatment at the time of intake. If a treatment group is not immediately available, the intake counselor will register the client for interim services, which shall begin no later than 48 hours after the intake.

The client has accepted interim services: _____Yes _____No _____ N/A

The client has been placed on a waiting list for _____ risk group, cycle_____ and is scheduled to begin on _____.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

Nicasa

Tuberculosis (TB) and HIV/AIDS Education

Client _____

Client # _____

Date _____

I have received educational information on this date regarding infectious disease control, Tuberculosis (TB) and HIV/AIDS. The counseling staff also provided information regarding testing sites for TB, HIV/AIDS, and infectious disease. This testing is provided free of charge through Lake County Health Department.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

Supplemental Questionnaire

(To be completed at all non-DUI Assessments and for clients entering treatment. Information should be incorporated into evaluation and treatment plan, as applicable.)

Client Name:_____ Client ID#:_____

Past and Current Medication History: (use additional sheets as necessary)

Medication	Taken for:	First Use	Dosage	Frequency	Last Use	Effectiveness	List any allergies or adverse reactions:

Gender, Sexual Identity, Gender Expression:

What is this person's stated gender? _____

What is this person's sexual orientation? _____

How does this client express their gender?_____

Relationships:

Please describe relationship with:

Family members: _____

_____

_____

Friends: _____

_____

_____

Community Members: _____

_____

_____

Other interested parties: _____

_____

_____

Trauma History- Please describe any history of trauma:

Type of Trauma:	Experienced	Witnessed
Abuse		
Neglect		
Violence		
Sexual Assault		

Literacy/Need for Assistive Technology:

Primary Language: _____ Secondary Language: _____

Read Fluently? Y/N Read Fluently? Y/N

Write Fluently? Y/N Write Fluently? Y/N

Speak Fluently? Y/N Speak Fluently? Y/N

Does this person use, or would they benefit from the use of any assistive technology?

Y/N If Yes, please explain: _____

_____

Social Supports: Please describe client's current social supports: _____

_____

_____

Please describe client's need for social supports: _____

_____

Advance Directives: Decisions about end of life care

Does this person have advance directives in place? Y/N

If No, would they like information about advance directives? Y/N

____ Initial that information was offered ____ Initial if information was accepted

Tuberculosis (TB) Screening:

Has Client ever tested positive for tuberculosis? Y/N

Has Client ever been treated for tuberculosis? Y/N

Do you have, or have you had any of the following symptoms?

-Long-term, low grade fever? Y/N

-Long-term weight loss? Y/N

-Sputum (a mixture of saliva and mucus coughed up from the respiratory tract? Y/N

-Coughing up blood? Y/N

* If Yes to any of the above questions, please see TB Information form in order to obtain necessary testing or services.*

_____ _____

Staff Signature Date

Nicasa
Behavioral Health Services

Effective February 29, 2016

Service Fees

EVALUATIONS

DUI	$150
Narrative Substance Abuse/Gambling	$200
Mental Health Assessment	$200
Locus Assessment	$100
Secretary of State Part 1	$100
Secretary of State Part 2	$500

INDIVIDUAL SERVICES

				Your costs
Substance Abuse/Mental Health	1 hour	@	$100	
Treatment Plan	1 hour	@	$100	
AODA Intake	1/2 hour	@	$25	
Moderate Intake	1 hour	@	$100	
Significant/High Risk/IOP Intake	1 hour	@	$125	
Youth Intake	1 hour	@	$100	

OUTPATIENT GROUP

				Estimated hours*	Estimated costs
Substance Abuse	1 hour	@	$28		
Mental Health	1 hour	@	$28		
AODA	1 hour	@	$14		
TRACK	1 hour	@	$10		

INTENSIVE OUTPATIENT GROUP

				Estimated days/ hours*	Estimated costs
Substance Abuse/Mental Health	1 day	@	$250		
or	1 hour	@	$28		

TOXICOLOGY

Urinalysis drug screen	$60
Redi Strip alcohol screen	$40

OTHER

				Estimated hours*	Estimated costs
Parenting	1 hour	@	$28		
GOALS/Retail Theft Intervention Program	total program	@	$140		
Employment Services	1 hour	@	$100		
Peer Support Services	1 hour	@	$100		

Estimated cost of your treatment $ _____

Fees are subject to change based on availability of funding. $25 No-Show/Cancellation fee will also be applied for missed appointments without advanced notice.

***Total number of hours/days is based on a client's individual treatment plan and progress and is subject to change.**

Client Signature _____ Date _____