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 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

Secretary of State Evaluation or Update Agreement

The burden of proof for any Secretary of State evaluation or update lies with the petitioner. Nicasa is not responsible for any additional work that results in a delay of hearing or a letter of denial.

Nicasa will complete the Secretary of State evaluation or update to the best of its ability utilizing all current rules, regulations and requirements stipulated by the Secretary of State. The Secretary of State evaluation or update is primarily based on the information obtained from the petitioner by Nicasa. It is imperative that the petitioner be honest in answering all questions.

By signing this agreement the petitioner understands the following:

Nicasa will perform and complete the evaluation or update to the best of its abilities, and

Nicasa does not guarantee the petitioner's driving privileges will be reinstated, and

The fee for today's service does not include an additional information requested by the Secretary of State, and

Nicasa's charge for any additional work requested by the petitioner is $50.00.

I have read and understand the above agreement.

_____
Printed Name of Petitioner

_____ _____
Signature of Petitioner Date

_____
Printed Name of Counselor

_____ _____
Signature of Counselor Date

Nicasa
Behavioral Health Services

Drug Testing Agreement

I, _____, understand that I am expected to undergo random urinalysis drug testing throughout my treatment. I further understand the results of these test will be confidential except for those parties identified through a written Release of Information statement. I understand that repeated positive drug test may be in violation of my treatment agreement and may result in a further referral.

Nicasa will perform a redi-screen test on all urine samples. If the test is positive, I have the right to have the test retested using an independent lab designated by Nicasa. I understand I will be beneficially responsible if there is a confirmed positive result.

If a 3rd party (i.e. referral source such as court or a community agency) requires that Nicasa test my urine using an independent lab in order to get levels, and I give permission to have this done, I will be responsible for the fee regardless of the test results. I understand that I have that right to refuse this retest for levels and that I am responsible for informing the 3rd party that I refused the retest.

I understand that if I refuse to take a drug test, it will be documented in my file and viewed as positive results.

Nicasa will hold all urine that tested positive via the redi-screen test for seven days. After this point, I understand that I will no longer be able to request a retest.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

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

COMPLETE THIS FORM AND BRING IT TO YOUR NEXT APPOINTMENT **Name:** _____

ALCOHOL AND DRUG HISTORY – list any and all drugs used or tried

EXAMPLE

Drug Alcohol
Age of first use 17 Last use 5/22/11
Frequency and amount used

AGE	TYPE	AMOUNT	ROUTE	FREQUENCY
17-20	beer	4-6	oral	twice per month
21-25	beer or whiskey	6 pack or ½ pint	oral	twice per week
26-37	beer or whiskey	4-10 or ½ pint - fifth	oral	5-6 times per week

Drug Alcohol Age of first use _____ Last use _____

AGE	TYPE	AMOUNT	ROUTE*	FREQUENCY

Have you ever experienced any of the following: (for example) hangovers, vomiting, blackouts, withdrawal, loss of appetite and/or weight loss? Others _____
Explain _____

Drug _____ (put name of drug here) Age of first use _____ Last use _____

AGE	TYPE	AMOUNT	ROUTE*	FREQUENCY

Have you ever experienced any of the following: (for example) hangovers, vomiting, blackouts, withdrawal, loss of appetite and/or weight loss? Others _____
Explain _____

Drug _____ (put name of drug here) Age of first use _____ Last use _____

AGE	TYPE	AMOUNT	ROUTE*	FREQUENCY

Have you ever experienced any of the following: (for example) hangovers, vomiting, blackouts, withdrawal, loss of appetite and/or weight loss? Others _____
Explain _____

CONTINUE ON ANOTHER PAGE WITH ANY OTHER DRUGS USED OR TRIED.

_____ _____
Client Signature Date