NORTH CENTRAL
BEHAVIORAL HEALTH
AN AFFILIATE OF ROSECRANCE

Health Directions HealthCare Agreement

(Health Directions is DBA of NCBH and NCBH is an Affiliate of Rosecrance)

Thank you for choosing Health Directions for your behavioral healthcare.
This HealthCare Agreement ("Agreement") explains the relationship between you and Health Directions regarding your behavioral healthcare, including expectations for our relationship, our obligations, and your obligations. Your signature on this Agreement indicates that you have had the opportunity to review, ask questions, and that you understood the content of the Agreement.
Except in cases of an emergency, YOU MUST SIGN THIS FORM PRIOR TO RECEIVING ANY SERVICES.

The Agreement contains the following sections:

A) Your consent (Consent for Treatment) to be treated by Health Directions.
B) Our notice about your rights and responsibilities (Notice of Rights and Responsibilities).
C) Our notice of privacy practices (Notice of Privacy Practices).
D) Your authorization to release your protected health information (Authorization of Release of Information) for care coordination and payment purposes.
E) Our financial agreement (Financial Agreement) guarantees your payment for services.
F) Information regarding psychological testing (Psychological Testing).

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Consent for Treatment

General Consent: Signing this Agreement indicates your consent to care and treatment by Health Directions, its employees, agents, and its contracted providers who are authorized by Health Directions to provide treatment and care to you. You give your voluntary consent to treatment at Health Directions and recognize that the success of your treatment rests in your willingness to cooperate in the voluntary treatment process.

Treatment by Independent Contractors: You understand that some of the healthcare professionals who will be part of your Health Directions care team may not be employees, agents, or apparent agents of Health Directions or its affiliates. You understand that you will have no vicarious liability or cause of action which holds Health Directions responsible for the negligent act(s) of a Health Directions employee or non-agent professional if those actions occurred within the scope of their employment. Treatment by Graduate Students, Interns, and Other Trainees: You care team at Health Directions may include graduate students, interns, or other trainees under the direct supervision of a licensed professional. You understand and give your consent to treatment and care from graduate students, interns, and other trainees. Alternative arrangements for a different behavioral healthcare provider can be made upon request.

Telehealth Services: You consent to receive treatment and services through telehealth, including active video and/or audio platforms which are HIPAA compliant. You consent to any inherent risks to your protected health information associated with telehealth services, including potential unsecure or unencrypted transmission, video and/or audio interruption(s), access by unauthorized persons, or unexpected disruptions from technical failures. Although it is unlikely, you understand that your protected health information may be disclosed if the technology fails or if it is breached.

Waiver and Limitation of Liability: To the fullest extent permitted by law, in no event shall Health Directions be liable for any indirect, incidental, punitive, consequential, exemplary, special, or consequential damages arising from or related to your receipt of Health Directions services. Health Directions total liability for any claim(s) will be the actual damages incurred by you, not to exceed the total amount paid by you to Health Directions for services in the twelve (12) months preceding the identified service. This limitation does not apply to claims resulting from Health Directions gross negligence, willful misconduct, or where otherwise prohibited by law.
As part of your treatment, you may have the opportunity to engage in optional nutrition, recreational and/or fitness activities that involve the inherent risk of injury. On behalf of yourself and all your heirs, assigns, or representatives, you hereby waive, release, and forever discharge Health Directions from all liabilities that might arise from your participation in these activities.

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Rights and Responsibilities

Health Directions has the dual responsibility to honor your rights and responsibilities which are important for you to understand. There are also legal limitations to those rights of which you should be aware. Your counselor/therapist at Health Directions also has corresponding responsibilities to you. These rights and responsibilities are described below.
Client Rights

Confidentiality: You have the right to have your information kept private and confidential, with information only released if authorized in writing or required by law.
Participation: You have the responsibility and right to actively participate in your own treatment.
Informed Consent: You have the right to be informed of the rules and expectations of your counselor/therapist and their qualifications including education, experience, national therapy/counseling certifications, and state licensure.

Safe Environment: You have the right to a safe environment for your treatment.
Receive Appropriate Treatment: You have the right to receive the least restrictive and most individualized services possible, and receive a written explanation of services offered, time commitments, fees, and billing policies prior to receiving services.

Ask Questions: You have the right to ask questions about all aspects of your treatment.
File a Complaint: You have the right to complain and receive a response to your complaint. You have the right to share any concerns or complaints you may have regarding a professional counselor's/therapist's conduct with the appropriate professional counseling/therapy organization or licensure board.

Exception to Confidentiality

Court Orders or Subpoenas: Your counselor/therapist may be required to release information in response to a court order.

Consultation: It may be necessary to consult with other mental health professionals, but your counselor/therapist will take care to avoid reveling your identity.
Mandatory Reporting: This includes situations such as knowledge of a threat to a specific person or suspected child, dependent adult, or elder abuse.
Insurance Requirements: Information may be disclosed to health insurers for claims or to collect overdue fees.

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Client Responsibilities

For your counselor/therapist to provide you with the highest quality of services, it is important that you:

- Adhere to established schedules. If you must miss an appointment, contact your counselor/therapist as soon as possible.
- Pay your bill in accordance with the billing agreements.
- Follow agreed-upon goals and strategies established in your sessions.
- Inform your counselor/therapist of your progress and/or challenges in meeting your goals.
- Participate fully in each session to help maximize a positive outcome.
- Inform your counselor/therapist if you are receiving behavioral healthcare services from another professional.

- Consider appropriate referrals from your counselor/therapist.
- Avoid placing your counselor/therapist in ethical dilemmas, such as requesting to become involved in social interactions or to barter for services.
- Ask questions about confidentiality and its limits specified in state and federal laws and professional ethical codes.
- Receive information about emergency procedures (e.g., how to contact your counselor/therapist in the event of a crisis).
- Ask questions about counseling/therapy techniques and strategies, including potential risks and benefits.
- Understand the implications of a diagnosis and the intended use of potential psychological reports.
- Obtain copies of clinical records and reports.
- Terminate the counseling/therapist relationship at any time.
- Share any concerns or complaints you may have regarding a professional counselor's/therapist's conduct with the appropriate professional counseling/psychotherapy organization or licensure board.

What to Do if You Are Dissatisfied

Remember that a counselor/therapist who meets the need of one individual may not meet the needs of another. If you are dissatisfied with the services of your counselor/therapist:

- Express concerns directly to your counselor/therapist if possible.
- Seek advice of your counselor's/therapist's supervisor.
- Terminate the counseling/therapy relationship if the situation remains unresolved.
- Contact the appropriate state licensing board, national certification organization, or professional association if you believe the counselor's/therapist's conduct to be unethical.

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Your Counselor's/Therapist's Responsibilities

The practice of psychotherapy has a dual responsibility to protect each client's confidentiality while also having exceptions to disclose information, such as to prevent harm or in response to a court order. Health Directions counselors/therapists have the right to ensure effective treatment, consult with colleagues (while protecting your identity), and refuse treatment suggestions if they believe it is not appropriate.

Maintain Confidentiality: Client counselor/therapist communication is protected by state and federal law, and information is only released with your written authorization and meeting specific legal requirements.

Report Specific Threats: Under Illinois law (like Tarasoff laws), your counselor/therapist has a duty to report or act if there is a serious, credible, threat to a specific, targeted individual.
Provide Quality Care: Your counselor/therapist is responsible for providing considerate, respectful, and safe care, as well as maintaining high ethical standards.

Explain Treatment: Your counselor/therapist must explain their qualifications, the techniques used, and the rules and expectations of Health Directions.

Comply with Regulations: Health Directions must comply with state and federal laws, such as HIPAA, and the recent legislation like the Wellness and Oversight for Psychological Resources Act, which prohibits the use of artificial intelligence for therapeutic decision-making.

Consult with Colleagues: Your counselor/therapist may consult with other professionals to get a case perspective, taking care to avoid revealing your identity during the consultation.
Counselor's/Therapist's Rights

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Counselor's?Therapistt's Rights

Ensure Effective Documentation: Your counselor/therapist has the rights to facilitate effective communication during sessions.

Refuse Inappropriate Suggestions: Your counselor/therapist can refuse treatment suggestions that they believe are not beneficial or appropriate for you.

Create Policies and Procedures: Your counselor/therapist can establish and communicate their own policies and procedures regarding things like cancellations and emergencies.

Maintain a Safe Environment: Your counselor/therapist has the right to create a safe environment and expect respectful interactions from you

Notice of Privacy Practices

This notice describes how treatment information about you may be used and disclosed and how you can get access to this information. Please review it carefully. By law we are required to inform you of our duties and responsibilities related to disclosure or use of your protected health information.

We respect your confidentiality and only release treatment information about you in accordance with Illinois and/or Federal law. Specifically, the Federal regulations of Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2), the Illinois Department of Mental Health and Developmental Disabilities Confidentiality Act (740 ILS 110/), and the Health Insurance Portability and Accountability Act (HIPAA) control the release of treatment information. This notice of privacy practice describes our policies related to the use of the records of your care that are generated by Health Directions.

Privacy Contact: If you have any questions about this notice or your rights or want additional copies, please contact our offices at 1-815-224-1610 and ask for the Director of Health Directions.

Use and Disclosure of Protected Treatment Information

To effectively provide you care, there are times when we will need to provide your treatment information with others beyond our practice.

Treatment: We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services.

Payment: Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval and planned treatment or for billing purposes if applicable.

Healthcare Operations: We may use information about you to coordinate our business activities. This may include operations such as setting up your appointments, reviewing your care, or training staff. We may at times enter into Business Associate Agreements with companies/organizations to perform these tasks. These Business Associates enter into an agreement with us to appropriately safeguard your information while doing their work.

Marketing: Health Directions does not sell personal health information. In the event we would be using personal health information for marketing purposes we would need to obtain your authorization and consent.

Breaches: By law we are required to protect your personal health information. In the event of a breach, you will be notified through first class mail.

Information Disclosed Without Your Consent

Under Illinois and Federal law, information about you may be disclosed without your consent in the following circumstances.

Emergencies: Sufficient information may be shared to address an immediate emergency you are facing. A disclosure of treatment information is required when there is a reasonable expectation that you are in imminent danger of self-harm, of harming others, or of being harmed by others, or you are clearly unable to provide for your own health and safety.

Follow-Up Appointments/Care: We may contact you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law: This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as in the case of communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors, and Organ Donation: We may disclose treatment information to a coroner or medical examiner and funeral directors for the purposes of carrying out their duties. When organs are donated sufficient information will be provided to the program as necessary to facilitate, the organ or tissue donation.

Governmental Requirements: We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure requirements.
Criminal Activity or Danger to Others: If a crime is committed on our premises or against our staff, we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

Your Rights

You have the following rights under Illinois and Federal law.

Copy of Record: You are entitled to inspect your treatment record Health Directions has generated about you. Health Directions may charge you a reasonable fee for copying and mailing your record. You have the right to receive a copy of your record. You have the right to receive a copy of your records in a secure encrypted format within 30 business days of request, when records are within the electronic health record.

Release of Records: You authorize in writing to release your records to others, for any purpose you choose. This could include family members, your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record: You may ask us not to disclose part of the treatment information. This request must be in writing. Health Directions is not required to agree to your request if we believe it is not in your best interest to permit use and disclosure of the information. You have the right to restrict personal health information to a health plan when you pay out-of-pocket in full for services rendered. Contacting You: You may request that we send information to another address or by alternative means. We will honor such requests if it is reasonable, and we are assured it is correct. We have the right to verify that the payment information you are providing is correct.

Contacting You: You may request that we send information to another address or by alternative means. We will honor such requests if it is reasonable, and we are assured it is correct. We have the right to verify that the payment information you are providing is correct.

Amending Your Record: If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this, contact the Director of Health Directions. In certain cases, we may deny your request. If we deny your request for an amendment, you have the right to file a statement that you disagree with us. We will then file our response and your statement, and our response will be added to your record.

Accounting for Disclosure: You may request an accounting of any disclosures we have made related to your treatment information, except for information we used for treatment, payment, or healthcare operations purposes or of that we shared with you or your family, or information that you gave us specific to authorization to release. It also excludes information we were required to release. To receive information regarding disclosures made for a specific time period no longer than six (6) years after April 14th, 2003, please submit your request in writing to the Director of Health Directions. We will notify you of the cost involved in preparing this list.

Questions and Complaints: If you have any question or have any complaints you may contact the Director of Health Directions. You may also contact the Secretary of Health and Human Services if you believe Health Directions has violated your privacy rights. We will not retaliate against you for filling a complaint. 42 CFR Part 2 violations can be reported to the U.S. Attorney for the judicial circuit in which you reside. Violations of 42 CFR Part 2 are subject to criminal penalty. Violations of HIPAA can be reported to the Office of Civil Rights.

Changes in Privacy: Health Directions reserves the right to change its Notice of Privacy Practices based on the needs of Health Directions and/or change in Illinois and/or Federal law.

Covered Entity Participants: Participants with other behavioral health service agencies (each a participating covered entity) in the Illinois Health Practice Alliance, LLC (IHPA) network established by IHPA ("Company"). Through Company, the participating covered entities have formed one or more organized systems of care in which the participating covered entities participate in joint quality assurance activities, and/or share financial risk for the delivery of health care with other participating covered entities, and as such qualify to participate in the Organized Health Care Agreement ("OHCA") as defined by the Privacy Rule. As OHCA participants, all participating entities may share personal health information of the clients for the health care operations purposes of the OHCA.

Authorization to Release Information

Authorization: You authorize Health Directions to disclose and receive protected health information for the purpose of treatment, payment, and health care operations from your treatment providers, health plans, third-party payers, and individuals assisting with the operations of Health Directions.

Recipients: You authorize Health Directions to disclose and receive information from your treatment providers, health plans, third-party payers, and individuals assisting with the operations of Health Directions. This includes exchanging information between and among Health Directions entities and affiliates.

Information to be Disclosed: You authorize Health Directions to disclose and receive the following information:

- Your presence in treatment
- Your demographic information
- Your treatment information including assessment, diagnosis, treatment plan, dates of service, type of service and level of care
- Financial information
- Any other information that is necessary to obtain authorization for services, to determine eligibility, to coordinate benefits, to submit healthcare claims, and to obtain reimbursement for services.

Purpose: You understand that this authorization will allow Health Directions to use your protected health information as allowed under applicable laws for all future uses and disclosures for treatment, payment, and behavioral healthcare operations, for example, receiving payment from your insurer or coordinating your care with other providers.

Redisclosure: You understand that your health information may be redisclosed in accordance with the permission contained in the HIPAA Privacy Rule, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you.

Fundraising: You authorize the use and disclosure of your demographic information for the purpose of fundraising for the benefit of Health Directions. You may opt out of any communications from Health Directions relating to fundraising.

Accounting of Disclosures: You have the right to request a list of disclosures of your protected health information made by Health Directions.

Restriction: You have the right to request restrictions on disclosures for treatment, payment, and healthcare operations.

Revocation: You have the right to revoke this authorization, in writing, at any time by sending a written notification to the Director of Health Directions, except to the extent that Health Directions has already acted in reliance on this authorization.

Expiration: This authorization will expire one (1) year from the date on which treatment at Health Directions is completed.

Financial Agreement

Health Directions is committed to providing quality care to our clients and ensuring transparent billing practices. Please review our financial information and billing practices below.

Guarantee of Payment: You agree to be financially responsible for all charges for services provided at Health Directions.

Insurance Billing: You agree to provide current and accurate insurance information regarding all active health insurance benefits. Health Directions will verify your benefits prior to starting treatment and will share this information with you, but this does not guarantee payment. You are responsible for all charges for services not covered by your insurance or that are required by your insurance plan, such as co-payments and deductibles. You are also responsible for all charges when insurance has declined coverage. All applicable insurance co-pays must be paid in full at the time of service.

Assignment of Benefits: In exchange for treatment by Health Directions, you assign to Health Directions your rights to receive payment of your authorized insurance benefits, as well as all rights, powers, authority, and standing to pursue amounts owed under your health insurance plan. This constitutes an express and knowing assignment of the Employee Retirement Income Security Act of 1974 (ERISA), a Federal law that sets minimum standards for most private sector employee benefit plans, such as health and retirement plans, breach of fiduciary duty claims and other legal and/or administrative claims. You authorize Health Directions to file appeals for any denial of payment or benefit determination.

Pre-Payment: Clients may be required to make a pre-payment prior to scheduling specific services. This pre-payment/deposit will be applied toward the cost of services provided. If you cancel your appointment later than 24 hours from your scheduled appointment, do not attend, or otherwise fail to initiate services, the pre-payment/deposit is non-refundable. In these cases, you forfeit the pre-payment/deposit and will not be returned or credited toward future services.

Self-Pay/Full-Pay Option: Health Directions offers a self-pay/full-pay option for services. You will be informed of the charges associated with treatment prior to beginning services.

Balance Statement: Your account balance will be the amount that your insurance carrier has determined to be your responsibility for your services. You will receive a statement detailing your responsibility for any services rendered. If your account balance remains unpaid for more than 90 days, Health Directions may refer it to a third-party collection agency. Please note that Health Directions must pay administrative fees when it refers your balance to a collection agency, no matter whether you pay Health Directions or pay the collection agency following that referral. If your balance is referred to a collection agency, and you elect to make a payment to Health Directions instead of the collection agency, you will be responsible for the re-payment to Health Directions of that administrative fee, which is equal to 25% of your payment.

Psychological Testing

The intent of this section is to enumerate and clarify the expectations that a test taker may reasonably have about the psychological testing process and the expectations that the testing clinician may have of the test taker.

Tests are defined broadly as psychological and/or educational instruments developed and used by testing clinicians in clarifying personality characteristics, symptom levels, intellectual and/or functional capacity, and to assist with a Diagnostic and Statistical Manual of Mental Disorders, Fifth (5th) Edition, Text Revision (DSM-5-TR) diagnosis(es) and/or treatment planning for behavioral healthcare disorders and/or psychological factors affecting medical conditions.

The rights and responsibilities identified in the document are not legally based nor are they inalienable rights, but rather represent the best judgments of the testing clinician about the expectations that those involved in the testing process should have. Test takers have the fundamental right to be able to take tests that meet high professional standards, such as those outlined in the Standards for Educational and Psychological Testing, the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education as well as other appropriate professional associations. State and Federal laws supersede any rights and responsibilities stated in this document.

As a Test Taker, You Have the Right Too:

- Be informed of your rights and responsibilities as a test taker
- Be treated with courtesy, respect, and impartiality, regardless of your age, disability, ethnicity, gender, national origin, religion, sexual orientation or other personal characteristics
- Be tested with measures that meet professional standards and that are appropriate, given the way the rest results will be used
- Receive a brief oral or written explanation prior to testing about the purpose(s) for testing, the kind(s) of tests used, if the results will be reported to you or to others, and the planned use(s) of the results. If you have a disability, you have the right to inquire and receive information about testing accommodations. If you have difficulty in comprehending the language of the test, you have the right to know in advance of testing whether any accommodations may be available to you.
- Know in advance of testing when the test will be administered, if and when test results will be made available to you, and if there is a fee for testing services that you are expected to pay.
- Have your test administered and your test results interpreted by appropriately trained clinicians who follow professional codes of ethics.

- Know if a test is optional and learn of the consequences of taking or not taking the test, fully completing the test, or cancelling the scores. You may need to ask questions to learn these consequences.
- Receive a written or oral explanation of your test results within a reasonable amount of time after testing and in commonly understood terms.
- Have your tests results kept confidential to the extent allowed by law.
- Present concerns about the testing process or your results and receive information about procedures that will be used to address such concerns.

As a Test Taker, You Have the Responsibility Too:

- Read and/or listen to your rights and responsibilities as a test taker.
- Treat others with courtesy and respect during the testing process.
- Ask questions prior to testing if you are uncertain about why a test is being given, how it will be given, what you will be asked to do, and what will be done with the results.
- Read or listen to descriptive information in advance of testing and listen carefully to all test instructions. You should inform the testing clinician in advance of testing if you wish to receive a testing accommodation or if you have a physical condition or illness that may interfere with your performance on the test. If you have difficulty comprehending the language of the test, it is your responsibility to inform the testing clinician.
- Know when and where a test will be given, appear on time with any required materials, and be ready to be tested.
- Follow the test instructions you are given and represent yourself honestly during the testing.
- Be familiar with and accept the consequences of not taking a test, should you choose not to take a test.
- Inform appropriate person(s), as specified to you by Health Directions for testing, if you believe that testing conditions affected your results.
- Ask about the confidentiality of your results, if this aspect concerns you.
- Present concerns about the testing process or results in a timely, respectful way, if you have any.

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By signing below, you are indicating that you have read, understood, and agree to all the provisions in the Agreement. You acknowledge that Health Directions staff have explained this agreement and all its provisions to you, and that you have been given the opportunity to ask questions and have no r emaining questions or concerns at this time.

Please refrain from signing this document until you are in the presence of your behavioral health professional. Thank you!

_____ _____
Client Name (print) *Client Date of Birth*

_____ _____
Client Signature *Date*

_____ _____
Name of Parent/Guardian/Personal Representative (print) *Date*

_____ _____
Parent/Guardian/Personal Representative Signature (if applicable) *Date*

_____ _____
Staff/Witness Signature *Date*