Easter Seals DuPage & Fox Valley

Rosalie Dold Center
Villa Park, IL 60181
630.620.4433

Lee A. Daniels Center
Naperville, IL 60540
630.357.9699

Jayne Shover Center
Elgin, IL 60123
847.742.3264

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Section A: Client complete for all authorizations. Please check and initial statement(s) that applies.

[ ] I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is **voluntary**. I understand that if the organization authorized to **receive** the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations. Initials: _____

[ ] I hereby authorize Easter Seals DuPage and the Fox Valley Region (ESD&FVR) to obtain individually identifiable health information as described below. I understand that this authorization is **voluntary**. Information obtained will be for the sole use of 'ESD&FVR' to provide treatment, receive payment or for health care operations purposes. Initials: _____

Client Name: _____ **Date of Birth:** _____

'ESD&FVR' may release to or obtain from as indicated below (physician(s), healthcare providers, educational program(s), or other agencies) my health information.

_____
Name, Address, Phone, Fax

_____
Name, Address, Phone, Fax

_____
Name, Address, Phone, Fax

_____
Name, Address, Phone, Fax

Description of information to be disclosed or obtained:

[ ] Evaluation/Assessment [ ] Progress Notes/Summary [ ] Medical History [ ] Discharge Reports
[ ] Psychological Reports [ ] IEP/School Records [ ] Medical Consultation [ ] Physical/Immunization Records
[ ] Other as here specified _____

Client or the Client's representativeread and initial the following statements:

1. I understand that this authorization will expire within one year from today's date. Initials: _____

2. I understand that I may revoke this authorization at any time by notifying 'ESD&FVR' in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions 'ESD&FVR' took in reliance upon my authorization before it received my revocation. Initials: _____

   You may revoke this authorization by making a written request of Revocation of Authorization. Please address your Request for Revocation of Authorization to: Easter Seals DuPage and the Fox Valley Region, 830 S. Addison, Villa Park, IL 60181, Attn: Privacy & Security Officer.

3. 'ESD&FVR' will not condition your treatment or payment for your health care services on your completing and signing this authorization.

Easter Seals DuPage and the Fox Valley Region personnel to complete for requests to obtain information:

1. The purpose of the use or disclosure is: [ ] Program Planning [ ] Other _____

2. Easter Seals DuPage and the Fox Valley Region _ will **X will not** receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO CLIENT: You or your representative may inspect and/or copy the health information in accordance with 'ESD&FVR's policies.

Section B: Must be completed by client or client representative for all authorizations.

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

_____ _____
Client's Representative Name *(Please Print)* **Relationship to Client**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Easter Seals DuPage & Fox Valley

NOTICE OF PRIVACY PRACTICES
2013 Version

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

Effective Date: April 14, 2003 with modifications as of September 22, 2013.

We respect patient/client confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by Easter Seals DuPage & Fox Valley (ESDFVR).

Privacy Contact. If you have any questions about this policy or your rights contact Jana Timm Perry, Director, Quality Services and Education, 630.282.2021.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond ESDFVR. This includes for:

Treatment. We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with your prescribing physician and others outside ESDFVR that we are consulting with or referring you to.

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 of planned treatment or for billing purposes. You have a right to restrict certain disclosures of your protected health information if you pay out of pocket in full for the services provided to you.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

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 the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting 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. We will leave appointment information on your voice mail or leave an email or text message unless you tell us not to.

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 communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners. We are required to disclose information about the circumstances of your death to a coroner who is investigating it.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. We are also required to share information, if requested, with the U.S. Department of Health and Human Services to determine our compliance with federal laws related to health care and to Illinois state agencies that fund our services or for coordination of your care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel 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.

Fundraising/Marketing. As a not-for-profit provider of health care services we need assistance in raising funds to carry out our mission. We may contact you to seek a donation or to participate in. You will have the opportunity to opt out of receiving such communication. You may also opt out of our providing your contact information for any marketing that results in compensation to ESDFVR.

PATIENT RIGHTS

You have the following rights under Illinois and federal law:

Copy of Record. You are entitled to inspect the client record ESDFVR has generated about you. We may charge you a reasonable fee for copying and mailing your record as outlined by State of Illinois guidelines.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. We may charge a reasonable fee for copying and mailing your record as outlined by State of Illinois guidelines. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization. Except as described in this Notice or as required by Illinois or Federal law, we cannot release your protected health information without your written consent.

Restriction on Record. You may ask us not to use or disclose part of the clinical information. This request must be in writing. ESDFVR is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the **Privacy Contact**.

ContactingYou. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. We also will be glad to provide you information by email if you request it. If you wish us to communicate by email you are also entitled to a paper copy of this privacy notice.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the **Privacy Contact** and ask for the *Request to Amend Health* Information Form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement along with our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years, please submit your request in writing to our **Privacy Contact**. We will notify you of the cost involved in preparing this list.

Notification of Breach. You have a right to be notified if there is a breach of your unsecured protected health information. This would include information that could lead to identity theft. You will be notified if there is a breach or a violation of the HIPAA Privacy Rule and there is an assessment that your protected information may be compromised.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our **Privacy Contact** in writing at our office further information. You also may complain to the Secretary of U.S. Department of Health and Human Services if you believe ESDFVR has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. ESDFVR reserves the right to change its Privacy Policy based on the needs of ESDFVR and changes in state and federal law.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at Easter Seals DuPage & Fox Valley and will make paper copies of the revised Notice of Privacy Practices available upon request.

ACKNOWLEDGEMENT - NOTICE OF PRIVACY PRACTICES AND CONTACT PREFERENCES

Client Name: _____ Date of Birth: _____
Please print

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Easter Seals DuPage & Fox Valley's Notice of Privacy Practices. Should I have questions in the future, I will contact ESDFVR's Director, Quality Services and Education or my Service Provider for assistance.

_____ _____
Signature, Patient or Patient's Legal Guardian/Date Relationship to Patient

CONTACT PREFERENCES

_____ I authorize Easter Seals DuPage & Fox Valley personnel to contact me about my services including scheduling, finance, and Center News using the following method(s):

_____ Home mailing address.

_____ Primary email address: _____
Please print

_____ Secondary email address: _____
Please print

_____ Telephone as indicated below.

Please indicate your phone contact preferences and any special instructions that you would like us to follow.

_____ Home Phone: _____ ___ ok to leave message ___ preferred

_____ Cell Phone: _____ ___ ok to leave message ___ preferred

_____ Work Phone: _____ ___ ok to leave message ___ preferred

____ I authorize Easter Seals DuPage & Fox Valley to contact me about activities and events, including information and educational sessions, special events for families, volunteer opportunities, and fundraising.

_____ I prefer to opt out of communications of this type.

_____ _____
Signature, Patient or Patient's Legal Guardian/Date Relationship to Patient

Easter Seals DuPage & Fox Valley
CONSENT FOR TREATMENT
SERVICE AGREEMENT

I wish to enroll my child/ward for services at Easter Seals DuPage & Fox Valley. I consent to services and understand the following:

- I understand that I am responsible for payment of these services.
- Easter Seals DuPage & Fox Valley (ESDFV) will provide the service of billing fees to a 3rd party agency as designated by me. I understand that I remain responsible for all co-pays, deductibles, co-insurance, and denied service fees. I must promptly notify ESDFV of any changes in my 3rd party payor and should contact my 3rd party payor to personally verify my benefits for all prescribed services. I understand that benefits verification is not a guarantee of payment. In addition, I understand that medical records will be released to my 3rd party payor as requested to facilitate payment.
- I understand that I must pay my personal balance in full upon receipt and that service interruption may occur if my account is 60 days or more past due.
- I understand that I am responsible for attaining necessary authorizations. If a required authorization is not received, services will be postponed until the authorization is obtained.
- I understand that therapy services are medically supervised by my prescribing physician and periodic progress summaries will be shared with both me and the prescribing physician. Services will not be provided without a valid prescription. Based on professional expertise and progress towards functional therapy goals, my therapist will recommend changes to the treatment plan including discontinuation of services, as appropriate.
- I understand that services are scheduled by appointment only. ESDFV must be informed of all cancellations no less than 24 hours prior to the scheduled appointment. A voicemail system is provided for after-hour messages. Failure to contact us prior to a scheduled appointment will result in a $25 ($100 for evaluations) NO SHOW fee. Every effort will be made by ESDFV to reschedule cancelled services; I agree to reschedule cancelled appointments whenever possible. I also understand that chronic cancellation can, and will, lead to discharge from ESDFV. Clients attending less than 75% of scheduled appointments in any three-month period are subject to discharge unless extenuating circumstances are discussed with your therapist. Failure to attend scheduled therapy sessions for two calendar weeks without notification will result in dismissal from ESDFV.

SIGNATURE: _____ DATE: _____

FULL NAME OF PARENT/LEGAL GUARDIAN: _____
Please Print

CLIENT NAME: _____
Please Print

HOME ADDRESS: _____

E-mail Address: _____

Home Phone: _____ Alternate Phone: _____

Easter Seals DuPage & Fox Valley
E-mail and Text Message Preferences

Client Name: _____ Date of Birth:_____

☐ **YES – Communicate with me by Email**

I have been notified that there is some level of risk that protected health information transmitted by unencrypted email could be read by someone other than me and I prefer you communicate with me by unencrypted email.

My email address is:

☐

☐ **NO – Do NOT Communicate with me by Email**

☐ **YES – communicate with me by text message**

I have been notified that there is some level of risk that protected health information transmitted by unencrypted text messaging could be read by someone other than me and I prefer you communicate with me by unencrypted text messaging.

My cell phone number is:

☐

☐ **NO – Do NOT communicate with me by text message**

Client Signature (parent/legal guardian if under 18 years of age). Please sign and date below.

_____

Signature **Date**

03/2016