Patient Name:_____ Date of Birth:_____

Account Number:_____

FHN FAMILY COUNSELING CENTER
INFORMED CONSENT

ADULT CONSENT

My signature confirms that I:

- Have been informed about the services FHN Family Counseling Center provides;
- Have been given a copy of the Client Rights Statement and it has been explained to me;
- Give my consent to participate in a mental health assessment that, with my participation, will be used to develop an individualized treatment plan; and
- Understand I will have the opportunity to discuss the recommended treatment with my case manager, therapist, nurse or psychiatrist, and that I have the right to refuse any treatment offered.

MINOR CONSENT

I, _____, give my permission to FHN Family Counseling Center to provide assessment, referral and treatment service to my minor child named above.

My signature confirms that I:

- Have been informed about the services FHN Family Counseling Center provides;
- Have been given a copy of the Client Rights Statement and it has been explained to me;
- Give my consent for my minor child to participate in a mental health assessment that, with his/her participation, will be used to develop an individualized treatment plan; and
- Understand I will have the opportunity to discuss the recommended treatment with my case manager, therapist, nurse or psychiatrist, and that I have the right to refuse any treatment offered.

Advance Consent for Treatment of Minors (MUST BE SIGNED BY PARENT OR GUARDIAN)

In those circumstances when the legal guardian or parent cannot accompany the minor for treatment, I understand the initialing of this paragraph permits FHN Family Counseling Center to provide treatment/procedure(s) to the unemancipated minor when accompanied by the following persons named or self if so indicated:

The minor may come for treatment alone _____ (Initials of Parent or Guardian)

Name: _____ Relationship to Minor:_____

Name: _____ Relationship to Minor:_____

USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I have been provided a copy of FHN's Notice of Privacy Practices, and understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examinations and test result, diagnoses, treatment, and any plans for future care or treatment. I understand that my health information may be used and disclosed among my health care providers for treatment purposes, and may be used and disclosed by health care providers and any insurance or other necessary health plan personnel in order to obtain payment of health care services. I also understand that such entities may use and share health information about me for certain health care operations, such as to assess quality and competency of health care professionals.

ACKNOWLEDGMENT OF LIMITS OF CONFIDENTIALITY AND MANDATED REPORTER STATUS

I, the undersigned, understand that all FHN Family Counseling Center Employees are mandated reporters under the Abused and Neglected Child Reporting Act (Ill. Rev. Stat. 1985, Ch. 23, pars. 2051 et seq.) This means they are required to report or cause a report to be made to the Child Abuse Hotline number (1-800-25A-BUSE) whenever they have reasonable cause to believe that a child known to them in their professional or official capacity may be abused or neglected. This pertains to any suspected abuse, past or present, to a minor under the age of 18.

I also understand that all FHN Family Counseling Center Employees are mandated as well to report any suspected incident of elder abuse or neglect (affecting adults 60 years of age or older). This means that they are required to report the abuse or neglect to the Stephenson County Senior Center (also covering Jo Daviess County) at 1-815-235-9777 or the Illinois Department on Aging After-Hours hotline at 1-800-279-0400.

I further understand my primary clinician, as well as other FHN Family Counseling Center Employees, are also obligated to break my confidentiality in the event I threaten harm to others or myself.

Under the Duty to Warn Act, I understand law enforcement and the alleged victim(s) will be informed if I threaten harm to another person or persons.

I affirm that I have read this statement and have knowledge and understanding of the limits of the confidentiality and mandating reporting status of the staff of FHN Family Counseling Center.

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE/MEDICARE BENEFITS

I authorize FHN Family Counseling Center/FHN to release medical information necessary to process this claim. Further, I assign directly to FHN Family Counseling Center/FHN any or all benefits otherwise payable to me, but not to exceed the regular charges. I understand I am financially responsible for charges not covered by this authorization and any deductible due upon receipt of the billing statement. Should the account be referred to an attorney or collection agency for collection, the undersigned may also pay reasonable attorney's fees and collection expenses.

I certify that I am the patient, the patient's legal representative, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

DO NOT SIGN UNLESS IN THE PRESENCE OF AN FHN EMPLOYEE.

My signature indicates that I am: (a) Giving the Informed Request described above; (b) Consenting to the Use and Disclosure of Protected Health Information by FHN/FHN Family Counseling Center for Treatment, Payment, or Healthcare Operations; (c) Acknowledging the Limits of Confidentiality and Mandated Reporter Status described above; (d) Giving permission for the Release of Information and Assignment of Insurance/Medicare Benefits; and (e) Acknowledging that I have the right to have all my questions answered about the treatment I may receive.

Patient Signature:_____ Date:_____
(12 years of age & up)

Parent/Guardian:_____ Date:_____

I HAVE EXPLAINED THE CLIENT'S RIGHTS TO THIS INDIVIDUAL, AND IT IS MY BELIEF THEY UNDERSTAND THESE RIGHTS.

_____ Date:_____