HopeSprings Counseling Services

Client Rights and Informed Consent

Client Name: _____ Date: _____

Client Rights: Your rights shall be protected in accordance with Chapter 2 of the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5). Your right to confidentiality is governed by the Illinois Confidentiality Act and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Consistent with these requirements, you have the following rights as a client of HopeSprings:

- The right to be provided with appropriate mental health services in the least restrictive setting.
- The right to be free from abuse, neglect, and exploitation from staff and other clients while receiving treatment at HopeSprings.
- The right to have your rights, as well as any services you receive, explained in a language or method of communication you understand.
- The rights guaranteed to you by the United States Government and the State of Illinois. Services will not be denied, suspended, terminated, or reduced because you exercise your rights.
- The right to receive services without discrimination. You will not be denied mental health services because of age, sex, race, religious belief, ethnic origin, marital status, physical or mental disability or criminal record that is unrelated to present dangerousness.
- The right to have disabilities accommodated as required by the American With Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS 5].
- The right to express opinions on issues concerning your case or treatment. You are considered to be competent (able to make decisions) unless a court has determined you are not.
- The right to have a copy of your Individualized Treatment Plan that describes the services that will be provided to you. Your Individualized Treatment Plan will be reviewed at least every six months.
- The right to participate in the development and review of your treatment plan, as appropriate. If you have concerns about your treatment plan or the services you receive, you and/or your guardian may request an in-house review of your care and treatment services by Cunningham staff not involved in your treatment.
- The right to review your treatment file.
    - If you are under the age of 12, your parent/guardian can view your file at any time.
    - If you are 12 or over, you can ask to review your file; however, your right to review your file may be limited to protect you or others from harm. If applicable, your parent/guardian always has a right to basic information about your treatment. Some records will not be released to your parent/guardian without your permission.

      You or your parent/guardian (if applicable) may write a note about any part of the file that is believed to be untrue. The note will be added to your file and included in any release of applicable record(s) .

      When you [or your parent/guardian (if applicable)] review your record, a staff member will be made available to answer questions and ensure the file remains secure.

- The right to confidentiality. If you are age 12 or over, you and your parent/guardian (if applicable) must give written consent to share information about you. Without your consent, records will not be shared unless your therapist believes it is in your nest interest.
    - If you are under 12, your parent/guardian must give written consent to share information about you.

    - In some cases your age does not matter and HopeSprings may release information without consent. Some examples include:
        - If you require hospitalization because you are at risk of hurting yourself or others.
        - If you have been abused, neglected, or exploited.
        - If required for reviews done by other agencies to determine if HopeSprings is following various rules, laws, and standards
        - Information related to crimes that occur on the property or against the staff of HopeSprings or involve immediate danger to someone else.
- The right for you or your parent/guardian (if applicable) to present grievances or to appeal adverse decisions related to the services you receive. The grievance process will be explained to you. A record of such grievances and the responses to those grievances will be maintained. You have the right to appeal decisions about your grievances to the highest level possible in the agency. The decision of the President/CEO and/or the governing body, when applicable, shall constitute a final administrative decision at the agency level.
- The right to contact the Guardianship and Advocacy Commission and Equip for Equality, Inc. Staff shall offer assistance to any client requesting to contact these groups. Contact information for these agencies, including address and telephone number, may be requested at any time and is also included in the Client Rights, Expectations and Responsibilities Handbook received by each client at intake. The Client Handbook includes additional contact information for other agencies that provide/support client advocacy.
- The right to contact the public payer or its designee, if applicable, and to be informed by the public payer (or its designee) of your healthcare benefit. You also have the right for the public payer (or its designee) to inform you of the process for filing a grievance. Contact information for various public payers is included in the Client Rights, Expectations and Responsibilities Handbook.
- The right to be notified of any restriction(s) of your right(s). Justification for any restriction to these rights shall be documented in your clinical record. Your parent or guardian (if applicable) as well as any agency you designate shall be notified of the restriction.
- You, or your parent/guardian (if applicable), have the right to refuse services. Refusal of these services may result in your case being closed when it compromises treatment and/or there is significant risk to your safety or the safety of others.

<u>Informed Consent</u>

- I am seeking services at HopeSprings Counseling Services, A program of Cunningham Children's Home. If I'm under the age of 18, I realize that my parent/guardian/funding agent is seeking services for me at HopeSprings.
- I consent to an assessment of my needs.
- I understand that a treatment plan will be developed based on an assessment of my needs and I will have the opportunity to participate in the development of the treatment plan.
- I consent to receive services offered by HopeSprings Counseling Services. A variety of treatment services are available to me to address my identified need (s). No guarantee or assurance has been given by anyone as to the results that may be obtained from services. I am responsible for actively participating in treatment services.
- I understand that there is the possibility of both risks and benefits. Treatment risks may include experiencing uncomfortable emotions (e.g., sadness). Treatment benefits may include a decrease in negative feelings and behaviors, improved relationships with others and ultimately, improvement in the quality of my life.
- I understand that if I present in a violent or threatening manner toward HopeSprings staff, I may be asked to enter a 30-day treatment contract which places expectations on my behavior in order to continue receiving services. I understand that these situations are managed on a case by case basis; however, if I continue to present in a violent and/or threatening manner, have multiple incidents of violent and/or threatening behavior over time, or are otherwise noncompliant with expectations, then my services could be terminated

prior to 30 days from the date of the treatment contract. I also understand that if I do not agree to sign the treatment contract, HopeSprings will discontinue my services at the time of my refusal.

- I understand that if my needs are assessed by my therapist to be beyond what traditional therapy can provide that I may be asked to enter a treatment contract requesting that I engage in specific type(s) of treatment (e.g., inpatient or outpatient substance abuse, take psychotropic medication, day treatment, or inpatient psychiatric, etc.). I understand that if I do not agree to sign the treatment contract, HopeSprings will discontinue my services at the time of my refusal. I also understand that if I do not comply with the conditions of the contract, HopeSprings will discontinue my services in 30 days from the date of the treatment contract.
- I understand that HopeSprings may wish to use staff observation as well as video/audio equipment as part of treatment services. Any video/audio recordings are for professional review only (staff training and supervision) and will not be made public. I will be informed prior to the use of any observation and/or video/audiotaping. I have the right to decline the use of observation and/or video/audiotaping.
- I have been apprised of my rights and I have been informed of the services offered by HopeSprings. I also have received this information in writing.

<u>Parent/Guardian</u>

- I am the parent or guardian of a minor or guardian of an adult seeking services.
- I consent to an assessment of this client's needs.
- I understand that a treatment plan will be developed based on assessment of this client's needs and I will have the opportunity to participate in the development of the treatment plan.
- I consent to this client's participation in the services offered by HopeSprings. A variety of treatment services is available to the client to address his/her identified needs(s). No guarantee or assurance has been given by anyone as to the results that may be obtained from services. Each client is responsible for active participation in treatment and services offered.
- I understand that there is the possibility of both risks and benefits. Treatment risks may involve the client experiencing uncomfortable emotions (e.g., sadness). Treatment benefits may include a decrease in negative feelings and behaviors, improved relationships with others and ultimately, an improvement in the quality of the client's life.
- I understand that HopeSprings may wish to use staff observation as well as video/audio equipment as part of treatment services. Any video/audio recordings are for the professional review only (staff training and supervision) and will not be made public. I will be informed prior to the use of any observation and/or video/audiotaping. I have the right to decline the use of observation and/or video audiotaping.
- I have been apprised of the client's rights and I have been informed of the services offered by HopeSprings. I have also received this information in writing.
- I am legally able to sign this form as this client's parent or legal guardian.

HopeSprings Counseling Services

Client Rights and Informed Consent Acknowledgement

I have been informed of the rights and responsibilities described above and understand how they apply to me as a client of HopeSprings Counseling Services. If I do not understand my rights or have questions about my rights and responsibilities, I may ask my therapist to explain them to me at any time.

_____

Client Name (printed) Date

_____

Client Signature Date

_____

Guardian Signature (if applicable) Date

_____

Witness Signature Date

As a Staff member of HopeSprings, I affirm that I have explained these rights to the client in a language or a method of communication he/she understands and believe these rights to have been understood. I have also reviewed the process for filing a grievance.

_____ _____

Staff Signature Date