ART OF RECOVERY SERVICES NFP
1512 ARTAIUS PARKWAY, STE 200, LIBERTYVILLE, IL 60048

Client Name: _____

Date of Birth: _____

Client ID: _____

CLIENT RIGHTS

It is the policy of Art of Recovery to protect and promote the rights of clients as human beings so that you will be treated respectfully and with dignity.

- Clients have the right to considerate and respectful treatment, free from abuse (this includes, but is not limited to, physical, sexual, psychological, and/or financial abuse), neglect, retaliation, exploitation, and humiliation. Clients also have the right to nondiscriminatory access to services as specified in the Americans with Disabilities Act of 1990 (42 USC 12101) and to have disabilities accommodated as required by that Act, section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS 5].
- Clients have the right to service regardless of ethnic background, color, race, creed, religion, sex, ancestry, sexual orientation, gender identity, nationality, age, marital status, disability, or HIV status.
- Clients have the right to protection in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (Ill. Rev. Stat. 1991, ch. 91 1/2, par. 2 - 100 et seq.) except that seclusion will never be used as a form of treatment.
- Clients have the right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
- Clients have the right to confidentiality as governed by the MHDDA Confidentiality Act (Ill. Rev. Stat. 1991, ch. 91 1/2, par. 801 et seq.), the Health Insurance Portability and Accountability Act of 1996, and as specified in Section 2060.319 of the Illinois Administrative Code, Part 2060. Clinical charts and information are available only to authorized agency personnel. Information released to or requested from other sources will require the written consent of the client.
- Clients also have the right to confidentiality of HIV/AIDS status and testing and anonymous testing as specified in section 2060.321 of the Illinois Administrative Code 2060.
- Clients shall be eligible to receive services irrespective of their ability or inability to pay for such services.
- Clients have the right to informed consent or refusal with regards to all aspects of their treatment, as well as the right to expression of choice regarding involvement in research projects. Art of Recovery adheres to research guidelines and ethics when clients are involved in research projects.
- Clients have the right to know what services are available to them and to participate in planning their treatment. Clients have a right to receive treatment in the least restrictive setting.
- Clients have the right to refuse treatment at any time; however, if a client presents a clear and present danger to him/herself or to others, the right to confidentiality may be waived to permit the clinician to take the steps necessary to protect the physical safety of the client and/or others. In the case of

suspected or known child abuse or neglect, the clinician will contact the legally authorized personnel as required by the Child Abuse Reporting Law, PA 81-1077.

- If it becomes necessary to restrict rights, clients have the right to be informed of the reason and duration of the restriction and conditions for reinstating their rights. This information will be documented in the clinical record. A plan will be developed with measurable objectives for restoring the client's rights and will be signed by the client, the client's parent or guardian (if applicable), the QMHP and the LPHA. The same people, as well as the Guardianship and Advocacy Commission and/or Equip for Equality (if designated by the client) shall be given a copy of this plan.
- Clients have the right to present grievances and to appeal adverse decisions of Art of Recovery, up to and including the Chief Executive Officer. The CEO's decision on the grievance shall constitute a final administrative decision and shall be subject to review in accordance with the Administrative Review Law (Ill. Rev. Stat. 1991, ch. 110, par. 3 - 101 et seq.).
- Clients have the right to access or referral to legal entities for appropriate representation, self-help support services and advocacy support services including the Guardianship and Advocacy Commission, Protection and Advocacy, Equip for Equality, Inc., Office of Mental Health, the Department of Children and Family Services (DCFS), Office of the Inspector General (OIG), and the Art of Recovery Critical Incident Review Committee, as appropriate. Art of Recovery staff shall offer assistance to clients in contacting these groups. The telephone numbers and addresses are also available and given to each client in their orientation manual. Art of Recovery ensures that OMH authorized consumer interest groups shall be permitted, with the consent of individuals, to visit the agency and living arrangements owned or leased by Art of Recovery.
- Clients have the right to use the services of professionals outside of Art of Recovery.
- Clients shall not be denied, suspended or terminated from services or have services reduced for exercising any of their rights.
- Clients have the right to have access to their own treatment records as well as timely information pertinent to the client to facilitate informed decision making.

Client name: _____ Date: _____

Client/Guardian Signature: _____

I, _____ explained Client Rights and personally witnessed Client/Guardian's signature.
Employee Name

Staff Signature: _____ Date: _____

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INFORMED CONSENT FOR TREATMENT AND PAYMENT

I, _____, consent to treatment by Art of Recovery Services NFP (AOR).

_____Myself; Name: _____ DOB: _____
_____Minor/Person for Whom I am Guardian; Name: _____ DOB: _____

All individuals under the age of 18 are eligible for services if they have obtained written parental consent or if they are otherwise permitted under Illinois law to consent on their own behalf to such care. In addition, a parent, legal guardian, or minor child who is permitted under Illinois law to consent on their own behalf has a right to refuse any health care services. Illinois State Law requires a parent's or legal guardian's consent to provide treatment to a minor child except for family planning, sexually transmitted infection services, and certain mental health services when the minor is 12 years of age or older. (325 ILCS 10/0.01 et seq.; 410 ILCS 210/0.01, 4, 5 et seq.; 740 ILCS 110/1, et seq.)

_____ (Initial) I agree to adhere to all facility policies for which I am responsible. The nature, purpose, risks and benefits of the treatment and possible alternatives have been or will be explained to me.

_____ (Initial) I hereby grant AOR permission to call for an ambulance in the event of emergency, injury, or accident requiring such action. I also specifically grant AOR permission to authorize medical services needed if I am unable to do so.

_____ (Initial) **I UNDERSTAND THAT I HAVE A RESPONSIBILITY TO ACTIVELY PARTICIPATE IN MY TREATMENT, INCLUDING THE DEVELOPMENT AND IMPLEMENTATION OF MY INDIVIDUALIZED RECOVERY PLAN. I HEREBY AUTHORIZE AOR TO PROVIDE MENTAL HEALTH SERVICES TO ME.**

AUTHORIZATION FOR RELEASE OF INFORMATION FOR PAYMENT

Services will be billed to Medicaid, Medicare or other third-party payers based on the information I provide. AOR reserves the right to bill me if the information I have provided is not valid. It is my responsibility to notify AOR of any changes in my healthcare coverage within 30 days of change and/or affected service dates. Failure to notify of changes may cause the charge for visits to become my responsibility. We do charge a usual and customary fee for services. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Your insurance policy is a contract between you and your insurance company. No one will be refused services because of an inability to pay.

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_____ (Initial) I authorize the AOR to release and/or send any medical information necessary for the processing and payment of my medical bills to any insurance company or third-party payer who may be responsible for paying any part of my medical treatment. This includes release to my employer for employment related injuries under worker's compensation claim. We will make every effort to ensure confidentiality in all transactions.

_____ (Initial) I, the undersigned, also give my consent to AOR to release all information necessary, including my name, date of birth and Social Security Number (SSN), family income and number of dependents, to the Illinois Department of Human Services (IDHS) and the Illinois Department of Healthcare and Family Services, in order to establish my eligibility for funding for my treatment. I understand that the release of my SSN is voluntary. Failure to provide my SSN may jeopardize funding for my treatment from state agencies and may make me responsible for payment for treatment. If I am required to provide toxicology testing as part of my care, I understand that my SSN may be used to report the results to IDHS.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

As a patient of AOR, I have been provided with its Notice of Privacy Practices, which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights. I acknowledge that I have received the Notice of Privacy Practices and understand how medical information about me may be used, the duties of AOR and my rights to privacy protection and access to my medical information. AOR will use and disclose my personal health information to treat me, to receive payment for the care they provide and for other health care operations. Health care operations generally include those activities they perform to improve the quality of care, including sharing information with health information exchanges and/or Record Locator Services. I understand that the Privacy Officer is available to answer any questions that I may have regarding issues of privacy. I also acknowledge that this Notice of Privacy Practices is not a contract between the AOR and the undersigned, but merely a notice of my privacy rights under state and federal law. The terms of the notice may change with time and the current notice will always be available online, posted at each of the facilities, and copies made available for distribution upon request.

_____ (Initial) I consent to participate and to work with staff to develop treatment goals and needs. I understand that students (nursing, medical assistant, medical, physician assistant, counseling, nurse practitioner, pharmacy), interns, residents and fellows may be involved in my care and I have the right to let my care team know if I do not want these individuals involved in my care.

_____ (Initial) I have been informed of my rights and responsibilities. I have received a copy of the Client Handbook and Client Rights. The terms of the Client Handbook and Client Rights may change with time. AOR will have copies of the Client Handbook and Client Rights available for distribution upon request. I understand that questions regarding rights,

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responsibilities, the Client Handbook and the Client Rights may be directed to the Privacy Officer.

A copy of this signed form may be available upon request.

I understand that Family involvement may be helpful in my treatment. Please check one of the following:

____ I agree to involve my family/significant other in my treatment. (Authorization for Release of Protected Healthcare Information is required)

____ I do not want my family/significant other involved in my treatment.

I have read and had the opportunity to ask questions and agree to the conditions stated above signature:

_____ _____

Patient Signature Date Parent/Guardian Signature Date

NOTICE FOR WITNESS: In witnessing this consent, I verify that I have explained the patient's rights and believe that the patient understands these rights. In order to ensure that the client is providing informed consent, I have explained the mental health services to be provided, the nature of treatment, possible alternatives treatments/services, and the potential risks and benefits of treatment to the client and the client's guardian, if applicable.

_____

Witness/AOR Employee Date

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NOTICE OF PRIVACY PRACTICES

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

At Art of Recovery Services NFP (AOR), we respect client confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice tells you about our policies related to the use of the records of your care generated by AOR.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION

At AOR, we understand that medical information about you and your health is personal and confidential. We are committed to protecting this information. We create a record of the care and services you receive for every visit. We need this record to provide quality care and to comply with legal requirements. All health records created by AOR are subject to these regulations. Business Associates are expected to follow all applicable state and federal statutes with regards to protected health information and are expected to protect the privacy of the protected health information they receive, create, or use in conjunction with, or obtain from, AOR.

This notice will inform you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your information.

You may consult our Privacy Officer to ensure that our Notice of Privacy Practices accurately reflects our privacy practices and those of any organized health care arrangements. We must check applicable state privacy law to determine if it provides greater privacy protections or rights than federal law. If so, our Notice must reflect those greater protections or rights. Our Privacy Officer must approve each Notice of Privacy Practices, including any joint Notice we may use for an organized health care arrangement to ensure that the Notice sufficiently complies with applicable federal and state laws before we may distribute the Notice.

The Notice must be distributed to each individual no later than the date of our first service delivery for the federal Privacy Rules established by the Department of Health and Human Services. Provider must also have the Notice available at the service delivery site for individuals to request to take with them.

Whenever the Notice is revised, we will make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, the Notice must be distributed to each new client/patient at the time of service delivery and to any person requesting a Notice

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YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your Record: You can ask to see or get an electronic or paper copy of your medical records or other health information that we have about you. Sometimes we may deny your request. If we do, we will tell you in

writing what our reasons are for the denial and how you can appeal the denial. We may charge you a reasonable fee for copying and mailing the documents you request.

Ask us to correct your Record: You can ask us to correct your health records if you think they are incorrect or incomplete. You must make the request in writing to the Trilogy Privacy Officer. We may say "no" to your request, but we will tell you why within 60 days.

Contacting you: You can ask us to contact you in a specific way. For example, you can ask that we contact you only by phone or e-mail. Put your directions in writing and give it to a staff person at the program where you receive services. We can turn down the request, but we will always agree to it if it is reasonable.

Ask us to limit what we use or share: You can ask us not to use or share certain health information. You can request a restriction by submitting your request in writing to our Privacy Officer. We are not required to agree and we can say "no" if it would affect your healthcare.

Restriction on Certain Disclosures of Health Information If You Pay Out of Pocket for Services:
If you pay for services wholly out-of-pocket, you can request that we not disclose information about that particular treatment to your health plan; we are required to honor that request.

Get a list of those with whom we've shared information: You can ask for a list of the times we've shared your information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except those about treatment, payment or healthcare operations and certain other disclosures (such as any you ask us to make). Please send your request in writing to the Trilogy Privacy Officer. We will respond to your written request within 60 days of receiving it. We may need to charge you a reasonable fee for your request.

Get a copy of this Privacy Notice: You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you a paper copy promptly.

File a Complaint. You can complain if you feel we have violated your rights by writing to the AOR Privacy Officer. You may also file a complaint with the United States Department of Health and Human Services, Office of Civil Rights by sending a letter to Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Bldg., Washington, D.C. 20201, OR calling 1-877-696-6775, OR visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

Authorization to Release your Record. For certain health information, you can tell us your choices about what we share, for example, sharing information with your family, close friends, or others involved in your care. These disclosures of your health information will be made only with your written authorization, unless otherwise permitted or required by law. You may withdraw or cancel that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made before you withdrew your permission.

Marketing Purposes. We will never share your information for marketing purposes unless you give us written permission. This includes never using or disclosing any of your protected health information that would constitute the sale of that information without your authorization.

Psychotherapy Notes. Should we have such notes, we will not share them without your written permission.

Fundraising. Because we are a not-for-profit agency, we need help in raising money. We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

The following categories describe different ways that we use and disclose protected health information. Not every use or disclosure in a category will be listed, and in some circumstances the disclosure of medical records, such as mental health and chemical dependency treatment records, may be further restricted by state or federal law. However, all of the ways we are permitted to use and disclose information will fall within one of the categories:

Help manage the treatment you receive: We can share information about you with other professionals who are treating you. For example, if you are in more than one Trilogy program, those programs will share information to decide which services work best for you.

Pay for your services: We can use and share your information in order to get paid for the treatment and services you receive, including your health insurance plan and other entities, like Medicaid or Medicare.

Run our organization: We can use some information about you to run our organization, improve your care, and contact you when necessary. This could be when we are evaluating the program you attend, training our staff, or when we are undergoing an audit and are required to share information, if requested, to determine our compliance with federal laws related to health care, to Illinois state agencies that fund our services, or for coordination of your care.

WE ARE ALLOWED TO SHARE YOUR INFORMATION IN OTHER WAYS THAT CONTRIBUTE TO THE PUBLIC GOOD.

Emergencies: We can share information as needed to deal with an immediate emergency you are facing. For example, we may tell an ambulance crew what medications you're taking.

Follow-up Appointments/Care: We can contact you with reminders of future appointments (we will leave appointment information on your answering machine unless you tell us not to). We might also tell you about benefits available to you or give you health-related information you might want to know about.

Court Order. We can share information about you in response to a court or administrative order, or in response to a subpoena.

Abuse or Neglect. We are required to notify government authorities if we suspect abuse, neglect or domestic violence.

Public Health and National Security. We may be required to share health information about you to government officials or military authorities that is necessary to complete an investigation related to public health or to national security; for example, health information could be important when the government believes that the public safety could benefit such as for preventing the spread of contagious disease, reporting adverse reactions to medications, or preventing or reducing a serious threat to anyone's health or safety.

Coroners, Medical Examiners or Funeral Directors: We must give health information to coroners, medical examiners, or funeral directors so that they can do their jobs.

Organ and Tissue Donation: We can share your health information to organizations that are involved in organ or tissue donation.

Research: We may share information with our research staff, but only if Trilogy has formally approved the research. Trilogy will approve research only if the Research Department has proven that when data is disclosed your health information will be kept private.

Workers' Compensation. We may share your health information as necessary to comply with laws related to workers' compensation or other similar programs.

Comply with the Law or When Required by Law. We may share information when if state or federal law requires it, including the Department of Health and Human Services to see that we are complying with federal privacy law. For example, if a crime is committed on our property or against our personnel, we may share information with law enforcement, so they can catch the criminal. We may also call the police or sheriff when we think someone is in immediate danger.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information in accordance with federal and state law.

Protecting Your Confidential Information. Please be aware that state and other federal laws may have additional requirements that we must follow or may be more restrictive than HIPAA on how we use and disclose your health information (such as those laws applicable to alcohol and drug abuse patient records (42 CFR Part 2) and mental health records (740 ILCS 110 et seq.)).

When we release information, we will not release more information than necessary. We will not share or use information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.

Notifying you of a Breach. You have the right to be notified if we discover there was a breach of your unsecured 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.

WE RESERVE THE RIGHT TO CHANGE THIS NOTICE AND OUR PRIVACY PRACTICES BASED ON THE NEEDS OF AOR AND CHANGES IN ILLINOIS AND FEDERAL LAW. THE NEW NOTICE WILL BE AVAILABLE UPON REQUEST AT OUR LOCATIONS AND ON OUR WEB SITE.

Effective date: March 19, 2023

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TELEMEDICINE INFORMED CONSENT FORM

1. I understand that my health care provider recommends engaging in Telehealth services with me to provide treatment and that there are many benefits to Telehealth, including easier access to care.
2. My health care provider has explained to me how the video conferencing technology will be used and that my telehealth visit will be similar to a direct patient/health care provider visit, except for the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that it is my responsibility to notify provider of any other persons at my location and that it is my responsibility to ensure privacy of my location (including disconnecting virtual assistant devises such as Alexa, Siri, Echo etc.)
5. I have had the alternatives explained to me, and I am choosing to participate in a Telehealth visit.
6. **I UNDERSTAND THAT TELEHEALTH IS NOT AN EMERGENCY SERVICE. IN THE EVENT OF EMERGENCY, I WILL USE THE PHONE TO CALL 9-1-1 AND/OR APPROPRIATE EMERGENCY CONTACT**
7. I understand that Telehealth visits are using the same Fee Schedule as regular in-person visits.
8. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to Telehealth. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
9. I understand that I can file a formal grievance in order to resolve any potential ethical concerns or issues that might come up as a result of Telehealth.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of Telehealth visit
- To maintain confidentiality, I will not share my Telehealth appointment link or information with anyone
- I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Was Verbal Consent obtained for this document by the client and/or guardian? Yes No

_____ _____

Client's/Parent/Guardian signature Date

_____ _____

Witness/AOR signature Date