



# INSTITUTE FOR HUMAN RESOURCES

P.O. Box 768 • 310 E. Torrance Ave. • Pontiac, IL 61764 • (815) 844-6109 • Fax (815) 844-3561

**Welcome!** You have taken a big first step in getting help just by coming to your first appointment. If you are a little nervous or overwhelmed, that is perfectly natural. We want to try to make you as comfortable as possible. You may have some questions on what to expect in coming to IHR. Let us try to explain a few things:

1. Getting started. The first session(s) you will have forms to fill out. We realize these may seem like a hassle, but they are all necessary to conform to guidelines set by the state as well as for our agency to have necessary information. If you have any questions or need assistance in filling out the forms, please let us know.

The first session is an *Assessment session*, specifically designed to gather information about you, make sure you understand confidentiality and your rights as a client, to make sure you understand the fee schedule, explain how it's important to have consistent appointments, how to cancel/reschedule an appointment, and to begin to understand what it is that brings you to IHR.

*This is the beginning of the therapeutic relationship*

2. It is important to have an open mind. Try to be willing, open, and honest with your counselor so you can take advantage of this opportunity to learn more about yourself. Overall, you will have a chance to not only solve the problem that brought you in, but also to learn new skills so you can better cope with whatever challenges arise in the future.
3. Your counselor may ask you a lot of questions. If you aren't ready to talk about a subject, it's ok to tell them you aren't ready. Be patient. By the end of the first few sessions, you and your counselor should have a good understanding of the issues and a plan for addressing them.
4. As services continue, it is important for you to be consistent in your attendance. . Insight and change occurs much more quickly if you can keep your appointments on a regular basis. If you cannot make it to a scheduled appointment, please call and let us know and then re-schedule your appointment as soon as possible.
5. We encourage you to be active and engaged in your treatment. It is a collaboration/relationship between you and your counselor. Your counselor may also assign you tasks to complete outside of the session and/or may suggest involving others in the process.
6. Change can be challenging; *practice* is a key in change. It's easy to fall back into old patterns, so be mindful between sessions, do your assignments, and be committed to the process.
7. If things in your situation change drastically, or you don't see progress; discuss it with your counselor. They are trained professionals and want your feedback. Don't immediately give up. If things just don't improve even after giving it some time, you and your counselor can discuss a change.



**FINANCIAL INFORMATION**

Family Income (please estimate if you do not know exactly) \$ \_\_\_\_\_/yr

Individual Income per year \$ \_\_\_\_\_

Source of Family Income (please check all that apply):

- Wages/Salary  XIX
- Public Aid/Food Stamps  Medicare
- Retirement/Pension  Medicaid
- Disability  VA Disability Income
- SSI  Other \_\_\_\_\_
- SSDI  None

Total Family size (including yourself) \_\_\_\_\_ Total number of dependents \_\_\_\_\_

Who lives in your household?

<u>Name</u>	<u>Age</u>	<u>Relationship</u>

Do you have insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, **please present your private insurance card to the receptionist** so a copy can be made for your file.

Do you receive Public Aid/Managed care? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, **please present your public aid card to the receptionist** so a copy can be made for your file.

What is your employment status?

- Full-time
- Part-time
- Unemployed
- Retired
- Homemaker
- Full-time student
- Sheltered employment
- Other \_\_\_\_\_

How long have you been employed?

- 0 - 3 months
- 4 - 6 months
- 7 - 12 months
- 13 months - 2 years
- Over 2 years

If employed, who is your current employer? \_\_\_\_\_

Are you a veteran? Yes \_\_\_\_\_ No \_\_\_\_\_

**E-MAIL INFORMATION**

IHR may send Client Surveys via e-mail. If you are willing to participate, please fill out the information below.

\_\_\_\_\_  
Name

\_\_\_\_\_  
E-Mail Address

IHR will only use this information for the purpose stated above. IHR will not distribute this information to a third party.

## Documentation of Consumer Choice to Receive DHS Funded Services

The Illinois Department of Human Services (DHS), Division of Mental Health and Division of Alcohol and Substance Use provides funding to community mental health agencies for qualifying people in Illinois who need these services. For consumers who are recipients of Medicaid or AllKids, this funding is part of the Medicaid program. For other consumers, IHR uses DHS funding to provide Community Support (respite), Alcohol and Substance Use, and related services. In the interests of consumer rights and compliance with federal laws about protected information, consumers must be informed when a provider bills DHS.

Under our contract with the Department of Human Services, Division of Mental Health and Division of Alcohol and Substance Use, IHR is required to inform a consumer when billing DHS for services. We must give the consumer the opportunity to refuse to have DHS pay for the treatment. It is not required that consumers consent, however, it is required that we notify you that the information described below will be submitted to DHS for billing purposes.

Therefore, DHS requires that for every consumer for whom IHR bills DHS for community mental health (Community Support and related services), or alcohol and substance use services the following form must be completed and maintained in the consumer's file, subject to review by DHS.

The Department of Human Services (DHS) may pay for some or all of the costs of your community mental health and alcohol and substance use services. If DHS is to pay for these services, the provider (IHR) must report certain personal information to the Department. If you do not want IHR to report this information, you may decline to be a recipient of DHS funding. If you decline to be a recipient of DHS funding, the provider may not be able to provide services to you. If you do not decline, the provider will report all of the following information to the Department of Human Services regarding the recipient of services.

- Full name (first, last, and middle initial of the recipient of services)
- Social Security number
- Birth date
- Gender (male, female)
- County of residence
- Family household income and size
- All mental health and alcohol and substance use services for which the provider expects payment (Community Support and related services).

**Consumer name** (please print) \_\_\_\_\_

To **ACCEPT** being considered as a DHS consumer

\_\_\_\_\_ I choose to have IHR bill DHS for services, and I understand IHR will report the information above to the Illinois Department of Human services.

\_\_\_\_\_  
Signature of Consumer or Parent or Guardian

\_\_\_\_\_  
Date

To **DECLINE** being considered as a DHS consumer

\_\_\_\_\_ I DO NOT choose to have IHR bill DHS for services, and I understand IHR will NOT report the information above to the Illinois Department of Human services.

\_\_\_\_\_  
Signature of Consumer or Parent or Guardian

\_\_\_\_\_  
Date

Explanation by the provider why consumer choice was not documented.

\_\_\_\_\_  
\_\_\_\_\_

**Consent for the Release of Information  
To Coordinate Care with Primary Physicians**

See attachment for a list of physicians

**A. PATIENT INFORMATION**

Patient Name \_\_\_\_\_  
(Last) (First) (Initial)

Patient Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Patient Date of Birth \_\_\_\_\_ Patient Phone Number \_\_\_\_\_

**B. PROVIDER INFORMATION**

IHR  
Provider Name  
P.O. Box 768  
(Address)  
310 E. Torrance Ave.  
(Street)  
Pontiac IL 61764  
(City) (State) (Zip)

**C. PRIMARY PHYSICIAN INFORMATION**

\_\_\_\_\_  
Primary Physician Name  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City) (State) (Zip)

Telephone Number 815-844-6109 Telephone Number \_\_\_\_\_

The undersigned authorizes the provider **and** primary physician to **release/obtain** the following medical records and information concerning patient. The purpose of such release is to allow for coordination of care, which enhances quality, and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

**Nature of the information** {X} diagnosis {X} prognosis {X} intake summary  
{X} discharge summary {X} treatment plan { } progress note {X} social history  
{ } psychological evaluation {X} medications {X} testing results {X} recommendations  
{X} psychiatric consultation { } legal history {X} medical history {X} drug/alcohol  
{X} attendance record { } other \_\_\_\_\_ history

**Purpose for Disclosure:** {X} Coordinating Services

**MY SIGNATURE BELOW WILL INDICATE THAT I HAVE READ AND UNDERSTAND THE INFORMATION WHICH FOLLOWS. I UNDERSTAND:**

1. That information will only be disclosed when this document is completed and signed by me and witnessed, except as provided by Federal and State Regulations on confidentiality.
2. That this consent may be modified or revoked by me at anytime upon written request to the party releasing the information, except to the extent that action has already been taken in reliance on this authorization.
3. That this consent will expire on \_\_\_\_\_ (date).
4. That I have the right to inspect or copy information to be released by IHR under the terms of this consent.
5. That failure to consent to such release of information may have an impact on the quality of services to be provided, but will not be grounds for termination of services by IHR.
6. The agency/person receiving information under the terms of this consent are not allowed to further release or disclose said information to any other person or agency without my specific written consent to do so.

I am willing that a reproduction of this consent be accepted with the same authority as the original.

SIGNATURE OF CLIENT: \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN (if client under 12) \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE \_\_\_\_\_ WITNESS \_\_\_\_\_

## CLIENT AGREEMENTS AND AUTHORIZATIONS

**\*\*\* Client/Guardian please initial each statement below (Guardian must initial if client is under 18).**

**CONSENT FOR TREATMENT/SERVICES.** I hereby consent to the treatment/services provided by the Institute for Human Resources and its employees or designees. I authorize the treatment/services deemed necessary to address my needs. (\_\_\_\_\_) **PLACE INITIALS HERE**

**AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.**

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Agency. I authorize the Institute for Human Resources to release any information required in the process of applications for financial coverage for the treatment/services rendered. This authorization provides that the Institute for Human Resources may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (\_\_\_\_\_) **PLACE INITIALS HERE**

**ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/ COLLECTION FEE.** I authorize payment to be made directly to the Institute for Human Resources for insurance benefits payable to me. I understand that I am financially responsible to the Agency for any covered or non-covered treatment/services, as defined by the insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees. (\_\_\_\_\_) **PLACE INITIALS HERE**

**PRIVACY POLICY.** I acknowledge having been offered the Agency's "Notice of Privacy Policies and Client Rights" statement. I understand that as a client of IHR my rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5], the Confidentiality Act and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. My right including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to record, is explained in the Policy. My right to make a complaint and file a grievance under Illinois laws has also been explained. I understand that I may revoke in writing my consent for release of my health information, except to the extent the Agency has already made disclosures with my prior consent. (\_\_\_\_\_) **PLACE INITIALS HERE**

**\*\*\* Guardian must sign if the client is under the age of 18**

\_\_\_\_\_  
Client Name Printed

\_\_\_\_\_  
Client or Authorized Person Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Client unable to sign. Verbal consent given. Reason \_\_\_\_\_

As staff member of IHR, I affirm that I have explained these rights to the client/guardian in a language or a method of communication he/she understands and believe these rights to have been understood.

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

*INSTITUTE FOR HUMAN RESOURCES  
310 E. TORRANCE AVE.  
PONTIAC, IL 61764  
(815) 844-6109*

**NOTICE OF PRIVACY PRACTICES  
AND CLIENT RIGHTS (HIPAA)**

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

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 this Agency.

Privacy Contact. If you have any questions about this policy or your rights, contact Joe Vaughan Executive Director.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Your right to confidentiality will be governed by the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS110) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond our Agency. This includes:

Treatment/Service Information. With your written consent, we may use or disclose treatment/service information about you to provide, coordinate, or manage your care or any related treatment/services, including sharing information with others outside our Agency that we are consulting with or referring you to.

Payment. With your written consent, information will be used to obtain payment for the treatment/services provided. This will include contacting your health insurance company for prior approval of planned treatment/services or for billing purposes.

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 Appointment/Care. We will be contacting you to remind you of future appointments or information about treatment/service alternatives or other health-related benefits and treatment/services that may be of interest to you. **We will leave appointment information on your answering machine 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 treatment/services.

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.

Notice of Privacy Practices: Covered Entity participates with other behavioral health services agencies (each, a "Participating Covered Entity") in the IPA Network established by Illinois Health Practice Alliance, LLC ("Company"). Through Company, the Participating Covered Entities have formed one or more organized systems of health 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 an Organized Health Care Arrangement ("OHCA"), as defined by the Privacy Rule. As OHCA participants, all Participating Covered Entities may share the PHI of their patients for the Treatment, Payment and Health Care Operations purposes of all of the OHCA participants.

## CLIENT RIGHTS STATEMENT

As a client of the Institute for Human Resources, you have the following rights under Illinois and federal law. Your rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (405 ILCS 5). You have the right:

1. To not be denied treatment/services on the basis of age, sex, race, religious beliefs, ethnic origin, marital status, physical or mental disability, sexual orientation, HIV status, or criminal record.
2. To treatment/services provided in the least restrictive environment available for your needs pursuant to an individualized treatment/service plan. You will have nondiscriminatory access to treatment/services in accordance with the Americans with Disabilities Act of 1990 (42 USC 12101).
3. Confidentiality of your status and records, including HIV status and testing as provided for under Illinois law. We are bound both by law and our own ethical code to respect your confidentiality. Clients with substance abuse issues are further protected by Federal Confidentiality Regulations (see 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, 1987). Moreover, all client records are governed by the AIDS Confidentiality Act (410 ILCS 305) and AIDS Confidentiality and Testing Code (77 Ill. Admin. Code 697). As per Section 7 of the Federal Privacy Act and the Federal Regulations on the Confidentiality of Alcohol and Drug Abuse Patient Records, disclosure of your social security number is required pursuant to federal regulations 42 U.S.C. Section 405 (c) (2). Your social security number may be used for identification, determination of Medicaid and contract eligibility for treatment/service, accumulation of benefits used across payers, and detection and possible prosecution of fraud. No information about a client will be discussed with or released to another person without a specifically signed consent from you, the client, except under very special circumstances.
4. Our Agency has the right to limit treatment/services based on the funding we receive. This may require us to prioritize treatment/services based on the severity of your treatment/service needs. Treatment/services not covered by governmental grants are charged based on the cost of providing those treatment/services.
5. No client shall be presumed legally disabled unless declared so by a court.
6. You have the right to give an informed consent to treatment/services. You also have a right to refuse treatment/services and be told the consequences of such refusal. This could include the Agency being unable to provide treatment/services to you.
7. If you believe your rights have been violated, you have the right to contact any of the following groups: Clients have the right to follow the agency's grievance procedure and to contact Equip for Equality, 422 E. Monroe St., Suite 302, Springfield, IL 62705 (800/758-0464), Guardianship and Advocacy, 421 East Capitol, Suite 205, Springfield, IL 62701 (217/785-1540), Office of Inspector General (800/368-1463), Illinois Department of Human Services (800/843-6154), and Department of Children and Family Services (309/828-0022). Staff shall offer assistance in contacting these groups if client so desires.
8. If you have a complaint about the treatment/services provided, you may file a grievance by doing the following: Individuals or guardians shall be permitted to present grievances and to appeal adverse decisions of the provider up to and including the executive director. A record of such grievances, appeals, and responses thereto will be maintained by the provider. The executive director's decision in the grievance shall constitute a final administrative decision and shall be subject to review in accordance with the administrative Review Law. (735 ILCS 5/Art.III).
9. Every client shall be free from abuse, neglect, financial or other exploitation, retaliation, and humiliation.
10. Individuals shall not be denied, suspended, or terminated from treatment/services or have treatment/services reduced for exercising any of their rights.
11. You have the right to be free from involvement in any research projects.

Copy of Record. You are entitled to inspect the client record our Agency has generated about you. We may charge you a reasonable fee of \$20 for appointment notes only and \$50 for copying entire file. Balance must be paid in full before copies are released.

Release of Records. You may consent in writing to release 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. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Contacting You. 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.

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 Officer** 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; your statement and 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/services, 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 specific time periods no longer than six years and after April 14, 2003, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.

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

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



**Institute for Human Resources**  
**310 E Torrance Ave., Pontiac, IL 61764**  
**(815) 844-6109**

**Client Rights**

**As a client of Institute for Human Resources, your rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5], the Confidentiality Act, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These rights include, but are not limited to, the following:**

1. You have the right to be provided with mental health or substance abuse services in the least restrictive setting.
2. You have the right to be free from abuse, neglect, financial and other exploitation, retaliation, and humiliation.
3. Justification for restriction of your rights as cited in Chapter 2 of the Mental Health and Developmental Disabilities Confidentiality Code [405 ILCS 5], the Confidentiality Act, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 shall be documented in your clinical record. You have the right to be notified of that restriction(s) of your rights. Your parent or guardian and any agency you designate (as listed in item No. 4 below) shall also be notified of the restriction.
4. You have the right to contact the Guardianship and Advocacy Commission and Equip for Equality, Inc. You have the right to be offered staff assistance in contacting these groups and staff will provide you with the address and telephone number of either of the above groups you wish to contact.
5. You have the right to contact the public payer.
6. You or your guardian has the right to present grievances up to and including the Executive Director, Joe Vaughan. A record of such grievances and the response to those grievances shall be maintained. The Executive Director's decision on the grievance shall constitute a final administrative decision (except when such decisions are reviewable by the provider's governing board, in which case the governing board's decision is final).
7. You are entitled to have your rights explained to you using a language or method of communication you understand, with such explanation placed in your record.
8. You have the right not to be denied, suspended or terminated from services or have services reduced for exercising any rights.
9. You have the right to be free from involvement in any research projects.

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I verify that I have read, understand, and have been provided a copy of my Client Rights.

\_\_\_\_\_  
Client or Authorized Person Signature

\_\_\_\_\_  
Date

I verify that I have been presented with, have read, and understand my HIPAA Rights.

\_\_\_\_\_  
Client or Authorized Person Signature

\_\_\_\_\_  
Date

As a staff member of Institute for Human Resources, 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.

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

## Some Information About You

1. Have you gained or lost weight recently? Y N
2. Do you sleep too little or too much? Y N
3. Are you depressed? Y N
4. Do you have too much anxiety? Y N
5. Do you have anger issues? Y N
6. Do you have memory difficulties? Y N
7. Are you presently suicidal? Y N
8. Have you attempted suicide in the past? Y N
9. Do you have thoughts of hurting someone else? Y N
10. Do you hear or see things that are not there? Y N
11. Have you ever been hospitalized for psychiatric reasons? Y N
12. Have you ever received substance use therapy? Y N
13. Have you ever received mental health counseling? Y N
14. Do you have a history of physical or sexual abuse? Y N
15. Do you have a family history of mental illness or substance use? Y N
16. Are you involved in a gang? Y N
17. Are you the victim of domestic violence? Y N
18. Are you having legal concerns? Y N
19. Are you seeing a psychiatrist? Y N
20. Would you like a referral to a psychiatrist? Y N
21. Do you have physical concerns that need some recognition by IHR? Y N
22. Do you have cultural considerations that need recognition by IHR? Y N
23. Do you feel you have some issues in being a good parent? Y N Not apply

Please give the name and age of the following people:

Father \_\_\_\_\_ Mother \_\_\_\_\_

Significant Other \_\_\_\_\_

Siblings \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_

Please list your typical, daily routine from waking to sleep \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any mental health medications you have taken in the past \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How do you expect counseling to help? What changes would you like to see? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## Notice of No Show Fee of \$20.00 Effective March 1<sup>st</sup>, 2019

At Institute for Human Resources the time the therapist spends with their clients is extremely valuable. If you fail an appointment, this represents time that could have been utilized by another client. It is our expectation that you will call and cancel appointments as needed and be respectful of our time and service. We would appreciate that you call at least 4 hours before your scheduled appointment to cancel and/or re-schedule. **If you do not call to cancel and miss an appointment, you will be charged the \$20.00 fee.** We realize things happen that are out of your control and we will take this in to consideration. You will have the opportunity to talk to your counselor about this on a case by case basis.

If within a 6 month period you fail more than two times you may be placed on a call-in list. This means you will have to call IHR each day to see if your therapist has an open appointment on that same day to schedule. You will remain on the call-in list for up to six months, at which time if you have not failed any appointments you can resume regular scheduling. This can be further discussed with your therapist.

The no show fee applies to appointments with Dr. Puga and Sherri Bowald, APN, as well. If you no show more than two times in a year, you will be discharged from their care and be provided one month of refills and a list of other providers in the area.

Please note that Medicare, Medicaid, Managed Care and/or private insurance **WILL NOT** pay this fee. You are responsible for the \$20.00 fee.



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## Notification of No Show policy

I understand that by signing below, I have been informed of IHR's \$20.00 no show fee.

I have had the opportunity read and understand the policy and ask questions as needed. I have been provided a copy of this policy for my records.

I understand the expectations of this policy.

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Print client/guardian name/Date                      DOB:

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Client/guardian signature/Date

---

Counselor signature/Date

# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Date: \_\_\_\_\_

If this questionnaire is completed by an informant, what is your relationship with the individual? \_\_\_\_\_

In a typical week, approximately how much time do you spend with the individual? \_\_\_\_\_ hours/week

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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**Client Copy**

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1. You have the right to be provided with mental health or substance abuse services in the least restrictive setting.
  2. You have the right to be free from abuse, neglect, financial and other exploitation, retaliation, and humiliation.
  3. Justification for restriction of your rights as cited in Chapter 2 of the Mental Health and Developmental Disabilities Confidentiality Code [405 ILCS 5], the Confidentiality Act, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 shall be documented in your clinical record. You have the right to be notified of that restriction(s) of your rights. Your parent or guardian and any agency you designate (as listed in item No. 4 below) shall also be notified of the restriction.
  4. You have the right to contact the Guardianship and Advocacy Commission and Equip for Equality, Inc. You have the right to be offered staff assistance in contacting these groups and staff will provide you with the address and telephone number of either of the above groups you wish to contact.
  5. You have the right to contact the public payer.
  6. You or your guardian has the right to present grievances up to and including the Executive Director, Joe Vaughan. A record of such grievances and the response to those grievances shall be maintained. The Executive Director's decision on the grievance shall constitute a final administrative decision (except when such decisions are reviewable by the provider's governing board, in which case the governing board's decision is final).
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