WARREN TOWNSHIP YOUTH AND FAMILY SERVICES
CLIENT INFORMATION

INSTRUCIONS: COMPLETE AND RETURN TO FRONT DESK

TODAY'S DATE: ___/____/____ ☐ **NEW CLIENT** ☐ **RETURNING CLIENT** ☐ **OTHER**

IDENTIFIED CLIENT

(If a specific child is the identified client, provide their information. If no single child is the identified client, the parent may list themselves as the identified client.)

_____ _____
CLIENT LAST NAME **CLIENT FIRST NAME**

DATE OF BIRTH: _____/____/____ **AGE:** _____ **GENDER:** ☐ **MALE** ☐ **FEMALE**

(IF APPLICABLE) **GRADE:** _____ **SCHOOL:** _____

RESIDENCE

(WHERE THE CLIENT RESIDES / INFORMATION REGARDING CLIENT)

_____ _____ **IL** _____
ADDRESS **CITY** **ZIP CODE**

HOME PH.: _____**MAY WE CALL?** ☐ **YES** ☐ **NO** **LEAVE MESSAGE(S)?** ☐ **YES** ☐ **NO**

CELL PH.: _____**MAY WE CALL?** ☐ **YES** ☐ **NO** **LEAVE MESSAGE(S)?** ☐ **YES** ☐ **NO**

***EMAIL ADDRESS PARENT / CLIENT** (18 YEARS OR OLDER)**:** _____

MAY WE CONTACT YOU VIA EMAIL REGARDING APPOINTMENT(S)? ☐ **YES** ☐ **NO**
MAY WE EMAIL INFORMATION ABOUT TOWNSHIP WORKSHOPS, GROUPS AND/OR EVENTS*? ☐ **YES** ☐ **NO**

PARENT/GUARDIAN INFORMATION

(IF THE CLIENT IS 17 YRS OLD OR YOUNGER OR RESIDES AT HOME)

MOTHER'S INFORMATION

_____ _____
MOTHER'S LAST NAME **MOTHER'S FIRST NAME**

_____ _____ **IL** _____
ADDRESS IF DIFFERENT THAN CLIENT **CITY** **ZIP CODE**

HOME/CELL NO.: _____ **MAY WE CALL?** ☐ **YES** ☐ **NO** **LEAVE MESSAGE?** ☐ **YES** ☐ **NO**

WORK NO.: _____ **MAY WE CALL?** ☐ **YES** ☐ **NO** **LEAVE MESSAGE?** ☐ **YES** ☐ **NO**

***MOTHER'S EMAIL ADDRESS** (IF CLIENT IS 17YR OLD OR YOUNGER): _____

IS THIS PARTY FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF THE SESSION(S)? ☐ **YES** ☐ **NO** (PLEASE CHECK YES OR NO)

FATHER'S INFORMATION

_____ _____
FATHER'S LAST NAME **FATHER'S FIRST NAME**

_____ _____ **IL** _____
ADDRESS IF DIFFERENT THAN CLIENT **CITY** **ZIP CODE**

HOME/CELL NO.: _____ **MAY WE CALL?** ☐ **YES** ☐ **NO** **LEAVE MESSAGE?** ☐ **YES** ☐ **NO**

WORK NO.: _____ **MAY WE CALL?** ☐ **YES** ☐ **NO** **LEAVE MESSAGE?** ☐ **YES** ☐ **NO**

***FATHER'S EMAIL ADDRESS** (IF CLIENT IS 17YR OLD OR YOUNGER): _____

IS THIS PARTY FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF THE SESSION(S)? ☐ **YES** ☐ **NO** (PLEASE CHECK YES OR NO)

WARREN TOWNSHIP YOUTH AND FAMILY SERVICES
CLIENT INFORMATION

GUARDIAN'S INFORMATION (This section is only completed if the guardian is neither parent)

_____ _____

GUARDIAN'S LAST NAME **GUARDIAN'S FIRST NAME**

_____ _____ **IL** _____

ADDRESS IF DIFFERENT THAN CLIENT **CITY** **ZIP CODE**

HOME/CELL NO.: _____ **MAY WE CALL?** ☐ **YES** ☐ **NO** **LEAVE MESSAGE?** ☐ **YES** ☐ **NO**

WORK NO.: _____ **MAY WE CALL?** ☐ **YES** ☐ **NO** **LEAVE MESSAGE?** ☐ **YES** ☐ **NO**

***GUARDIAN'S EMAIL ADDRESS** (IF CLIENT IS 17YR OLD OR YOUNGER): _____

IS THIS PARTY FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF THE SESSION(S)? ☐ **YES** ☐ **NO** (PLEASE CHECK YES OR NO)

EMERGENCY CONTACT

_____ _____ _____

FULL NAME **RELATIONSHIP** **PHONE NO**

REFERRAL INFORMATION

☐ **WOODLAND DIST. 50 SCHOOL** ☐ **GURNEE DIST.56 SCHOOLS** ☐ **WTHS** ☐ **FRIEND/FAMILY** ☐ **OUTSIDE THERAPIST** ☐ **NEWSPAPER**

☐ **NEWSLETTER** ☐ **FLYER** ☐ **WEBSITE** ☐ **SELF-REFERRED** ☐ **LAKE COUNTY HEALTH DEPT.** ☐**SEDOL** ☐ **COURT SERVICES**

☐ **POLICE DEPARTMENT** ☐ **OTHER**_____

DEMOGRAPHIC INFORMATION

RACE: ☐ **AFRICAN-AMERICAN** ☐ **ASIAN-AMERICAN** ☐ **CAUCASIAN** ☐ **LATINO** ☐ **NATIVE AMERICAN** ☐ **OTHER**

CLIENT HOUSEHOLD: ☐**SINGLE-PARENT** ☐**TWO-PARENT** ☐ **BLENDED (STEP)** ☐ **RELATIVE CARE** ☐ **FOSTER CARE** ☐ **OTHER**

MARTIAL STATUS OF PARENT(S) / CLIENT: ☐ **DIVORCE** ☐ **LIVING COOPERATIVELY** ☐ **MARRIED** ☐ **NEVER MARRIED**

☐**SEPARATED** ☐ **SINGLE** ☐ **OTHER**

CUSTODY ARRANGEMENTS IF DIVORCED/NEVER MARRIED: _____

_____

*** UNDER NO CIRCUMSTANCE WILL YOUR EMAIL INFORMATION BE SOLD OR SHARED OUTSIDE OF WARREN TOWNSHIP YOUTH SERVICES***

STAFF ONLY
ENTERED BY: _____ DATE: _____

WARREN TOWNSHIP YOUTH & FAMILY SERVICES
INFORMED CONSENT

We would like you to fully understand several important aspects of how we work. Please read this and ask for clarification if necessary before you sign.

YOUR CONFIDENTIALITY

Confidentiality is our highest priority. All members of your therapy team are required by legal and ethical standards to maintain strict professional confidentiality.

Except in very unusual situations you can be certain that what you say in your sessions will be known only to yourself and the therapist(s) participating in the family therapy program. The exceptions include the following:

1. Disclosure of intent to harm yourself or others.
2. Disclosure of knowledge of felony crimes that could result in death or serious injury.
3. Information about child and elder abuse or neglect.
4. Finally, we will attempt to maintain your confidentiality according to the ethical standards of our profession. However, information that you wish to keep from a family member may not be considered privileged information by a court of law.

COUNSELING GUIDELINES

We have chosen to discuss the guidelines of counseling out of an ethical commitment. We hope this will help you make an informed choice to participate with us in addressing your concerns. This commitment will carry through your counseling. At any time you may ask us to explain why we're gathering information or prescribing a new approach. We will be glad to explain the purpose behind our practices. In addition to the gains and positive outcomes that are associated with counseling and therapy, some "side effects" are possible. Because counseling involves discussing issues that have or are presenting you with some difficulty, you may find: 1) the energy it takes to focus on your issue(s) may make it harder to concentrate on other things as much as you'd like; 2) emotions may be more available to you and you may feel moodier; 3) you may see things in new or different ways and this may be confusing or difficult for a short time; and 4) relationships may be affected as you examine interpersonal issues.

NONVOLUNTARY DISCHARGE FROM SERVICES

A client may be terminated from services non-voluntarily for the following reasons: (A) the client exhibits intimidation, physical violence, verbal abuse, carries weapons, or engages in illegal acts at the center; (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner; and/or (C) chronic non-improvement or clinical issues requiring greater expertise may be a reason for a referral or termination. The client will be notified of discharge and may appeal the decision to the Director or reapply for services.

GROUP COUNSELING

Records related to group counseling sessions are maintained in a client's individual record with the identifying information for other group members removed. Facilitators of skills-based groups, such as social skills training, do not provide individual records of progress, but attendance is recorded in the group file. Although the information discussed in group sessions is considered confidential by staff, confidentiality by other group members cannot be guaranteed. Confidentiality will be discussed and strongly encouraged among all group members as a vital part of group membership. Support groups, which are not clinical in nature, do not retain any record of attendance or participation.

USE OF ASSESSMENT AND SCREENING TOOLS

The therapists may use screening or assessment tools such as the Behavioral Assessment System for Children (BASC-3) and Columbia Screen. Other assessment/screening tools may be used throughout the therapy process and will be reviewed in advance with the client and guardian/parent. Some tools may be used to measure weekly progress, while other tools may be use for more diagnostic purposes. Children requiring a more thorough evaluation may be referred to clinical psychologist for further testing.

PRIVACY OF THERAPY SESSIONS FOR CHILDREN

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Children seen in individual sessions must feel they have privacy when speaking with a therapist or the benefits of therapy may be lost. Parents requesting to view their child's file or subpoena those files for court, even when they may have a legal privilege, undermine confidentiality and may make effective treatment impossible and result in termination of the therapy.

Parents should not inquire about the content of any private sessions, without first consulting with the therapist. If a child prefers not to volunteer information about the sessions please respect his/her right not to disclose details. Unless the child has been abused or there is a clear danger to self or others, the therapist will normally tell the parent only the following:

- Whether sessions are attended
- Whether or not your child is generally participating
- Whether or not progress is generally being made and general focus of the sessions
- Sometimes provide information about a task or assignment

Similarly, when the therapist determines that there are significant issues that should be discussed with the parents, every effort will be made to schedule a session involving the parents and the child/children. If information becomes known to the therapist that has a significant bearing on the child's well-being, the therapist will work with the person providing the information to ensure that parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

AGENCY POLICIES

Warren Township Services does not become involved in contested child custody or visitation disputes and will not provide documents to the court or attorneys related to these matters or any other court related matters. All services are voluntary and WTYS will not keep a case active if the only reason is to fulfill a *court order*. If you are seeking our services as part of a court order or probation, notify us at the opening of your case and the Director will determine if Youth Services can provide documentation of your attendance to the court.

Under Illinois law (405 ILCS 5/3-3/02), minors age 12 and over may receive counseling services or psychotherapy on an outpatient basis without parental/guardian consent for no more than five (5) sessions, each session lasting no more than 45 minutes.

Warren Township Youth Services is a not-for-profit and a department of the Township. The services are largely funded through tax revenues, but clients are responsible to pay for any fees for services (see Financial Agreement). To be respectful of families on the waiting list, and the growing needs of the community, we ask you to attend sessions regularly. SERVICES MAY BE TERMINATED WHEN CLIENTS MISS TWO OR MORE COUNSELING SESSIONS OR ARE UNABLE TO BE CONTACTED. Please give at least 24 hours notice if you must cancel an appointment. You can leave a message 24 hours a day at 847-244-1101 x therapist's extension.

This document must be signed by any minor 12 years of age or older. When you have read to this point and have asked for clarification if necessary, please sign below:

My signature below indicates that I give my full and informed consent to receive services.

Print Client or Guardian	Date	Signature	Date
Print Client or Guardian	Date	Signature	Date
Client (12 or over)	Date	Signature	Date
Therapist/Witness	Date	Signature	Date

WARREN TOWNSHIP YOUTH & FAMILY SERVICES
FINANCIAL AGREEMENT

Costs:

The first scheduled session is at no cost. For all sessions that follow, Township residents will pay at the rate of $10 per session (average session lasting between 45-60 minutes.) Those sessions lasting 30 minutes or less may be charged at half the rate. Those non-residents attending Districts 50, 56 or 121 will be charged $40.00 per session.

Payment Policy:

The Client/Guardian is expected to pay for all fees at the time of services, unless special arrangements have been made. Warren Township **ONLY accepts cash and checks**. There is a $25.00 fee for returned checks. WTYS understands that financial problems may affect the Clients/Guardians ability to pay for service on specific occasions. Please communicate to the staff those challenges and make appropriate arrangements.

Fee Reduction:

Township residents may request a Fee Reduction based on hardship or lack of funds. Please ask the front desk for the Fee Reduction Form. All fee reductions will be approved by the Director and clients will be asked to pay something for services. No Township resident will be refused vital services because of a legitimate inability to pay.
Minors who seek services without parental consent (405 ILCS 5/3-3/02) and their guardians assume no financial responsibility. These sessions are provided at no charge, with the approval of the Director.

Insurance:

Warren Township Youth Services (WTYS) is out-of-network. Most, if not all, insurance companies directly reimburse the Client/Guardian for services received. Please notify the staff if you have forms that need to be submitted for your insurance or flex plan and we will print out copies so that you may mail/fax your insurance company or flex plan.

Divorce Situation:

Warren Township looks to the adult who has brought the child for the appointment to be responsible for payment of services which are rendered to the child. WTYS also expect parents to be able to work out payment arrangements with each other and not involve our office in any disputes which may arise.

Cancellation Policy:

Unless appointments are cancelled at least 24 hours in advance of their scheduled time, there will be a charge for the full rate placed on the account.

Collection Costs and Procedures:

If the account becomes delinquent, the Client/Guardian agrees to pay any additional charges to collect the unpaid bills, including, but not limited to, reasonable attorney fees, court costs and collection agency fees.

Assignment and Release:

I fully understand that I am the responsible party for all charges incurred by me or my dependents at WTYS. I also authorize the release of any and all information required to collect or process my claims. If legal action becomes necessary, I agree to pay all reasonable fees. *By signing below, you do affirm that you read and understood our Financial Policy and that you agree to its contents.*

PRINT CLIENT FULL NAME: _____

PRINT NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO CLIENT: _____

SIGNATURE OF RESPONSIBLE PARTY: _____

DATE: _____

STAFF ONLY WITNESS SIGNATURE: _____

Explanation of Policies Regarding Minors of Divorces, Separated or Never Married Parents

Involvement and Contact of Non-Referring Parent

Warren Township Youth Services believes that it is a necessary for legal and ethical reasons to ensure that the parents/guardians (referring and non-referring) are notified of and allowed an opportunity to participate in therapy (when clinically appropriate). Parents/Guardians who are separated, never married or divorced may be required to bring in documentation if they wish for the non-referring parent to not be notified or involved in the therapy.

- WTYS believes that services should be viewed as neutral and failure to engage both parents creates the appearance that sides are being taken.
- WTYS believes it is clinically necessary to engage both parents to effectively address issues concerning children.
- Failure to notify or engage a non-referring parent risks creating an air of secrecy regarding therapy. Therapy requires both openness and honesty to succeed.
- Parents with legal custody must be notified if their child is receiving services. This is separate from clinical concerns, but must also be taken into consideration.

If there are specific clinical, safety or other reasons to withhold notifying the non-referring parent, please make your therapist aware of these reasons. Circumstances will be reviewed on a case-by-case basis.

In cases where both parents wish to have no direct contact with each other, it may be recommended to have parents alternate bringing the children to sessions.

Notifying the non-referring parent is not the same as *direct involvement* in therapy. It is at the therapist's discretion to determine who is and is not directly involved in the therapy sessions. In most cases, the therapist will ask the referring parent to notify the non-referring parent prior to or just after the first session. Assuming there are no outstanding concerns, the therapist will reach out to the non-referring parent soon after.

This document must be signed by any minor 12 years of age or older.

My signature below indicates that I have been made aware of and fully understand the above policy.

Print Client or Guardian	Date	Signature	Date
Print Client or Guardian	Date	Signature	Date
Client (12 or over)	Date	Signature	Date
Therapist/Witness	Date	Signature	Date

Updated.1-2017

WARREN TOWNSHIP YOUTH AND FAMILY SERVICES

EXPLANATION OF POLICY REGARDING CLIENT RECORDS AND REPORTS

Reports or use of client records for court, legal disputes and mediation

It is Warren Township Youth Services (WTYS) policy not to provide reports, testimony or clinical records to the court or its representatives regarding custody, visitation, criminal or other civil matters.

- WTYS wishes to remain a neutral party and be available to all residents. Providing a progress report, assessment or any record/documentation may influence what happens in court and result in an adversarial relationship with one or both parties.
- The counseling services are intended to remedy problems and require honesty from all parties involved. When a therapist reports to the court or the records from counseling sessions are brought into court, parents and children are more likely to withhold information or attempt to control what is disclosed in session.

Because our role is that of the child's and family's "helper," WTYS will not become involved in legal disputes or other official proceedings. Matters involving custody, visitation and mediation are best handled by another professional who is specially trained in those areas rather than by the child's or family's therapist.

Signing this document indicates that you will not directly or indirectly through a third party involve any member of the Warren Township Youth Services staff in any type of custody or visitation litigation or other civil litigation. You understand that if you, an attorney or advocate subpoenas the records or the testimony of a therapist, that the Township will share this agreement with the court so that the subpoena will be quashed. By signing this agreement you indicate that you will be responsible for any legal fees ($250.00 an hour) in the event Warren Township is forced to fight any type of subpoena in a custody, visitation or other civil dispute.

Children under 12 should have the content of this document carefully explained to encourage openness and clinical success. Children 12 and older must sign the form after reading.

Client (Parent/Guardian): _____ Date: ___/___/___

Client (Parent/Guardian): _____ Date: ___/___/___

Child (12 and over): _____ Date: ___/___/___

Therapist: _____ Date: ___/___/___

ANNONOYMOUS CLIENT QUESTIONNAIRE

Please Read

Please complete the following questionnaire. The information gathered is anonymous and will not affect eligibility to receive services. The form is to be completed by an adult or parent. Only 1 form per family.

Type of Service

❑Family/Child Therapy ❑Individual Adult Therapy ❑Marital Therapy

Presenting Problems (*check all that apply*)

Children (*parents complete if children are receiving services*)
❑School Issues ❑Attention/Impulse Problems ❑Drug/Alcohol ❑Parent/Family Conflict
❑Divorce/Separation Issues ❑Loss/Grief ❑Aggression/Violence ❑Self Injury ❑Suicide Thoughts/Attempts
❑Anger Management ❑Issues Around Eating ❑Delinquency/Legal Problems ❑Gang involvement ❑Anxiety ❑
Depressed/Sad ❑Social Skills ❑Running Away ❑Dealing with Sexual Abuse ❑Sexual Orientation
❑Hallucinations/Delusions ❑Personal Growth ❑Other_____

Adults/Parents (*identify the problems the adults are experiencing*)
❑Parenting Skills ❑Marital Issues ❑Attention/Impulse Problems ❑Drug/Alcohol Use
❑Divorce/Separation Issues ❑Loss/Grief ❑Domestic Abuse ❑ Dealing with Abuse ❑Self Injury ❑Suicide Thoughts/
Attempts ❑Anger Management ❑ Issues Around Eating ❑Depressed/Sad Problems ❑Anxiety ❑Sexual Orientation
❑Employment/Financial ❑Hallucinations/Delusions ❑Personal Growth ❑Other_____

Reason for Choosing Warren Township

❑Positive experience in the past ❑Free services ❑Positive reputation/referred by someone trusted ❑No insurance
❑Required to attend ❑Other_____

Personal and Family History (check all that apply)	**Yes**
Have you or any adult in the home been the victim of domestic violence?	❑
Do you or anyone in the home have a diagnosed mental disorder (e.g., depression, bipolar, etc.)?	❑
Have you or anyone in your home received services here (WTYS) in the past?	❑
Have you or anyone in your home been involved with child protective services (now or in the past)?	❑

Financial (this in no way affects your services)

Does the family have insurance that would cover all or a portion of counseling services?	❑
What is the total household income? ❑0-15,000 ❑15,001-32,000 ❑32,001-50,000 ❑50,001-80,000 ❑80,001-125,000 ❑125,001 or Above	
Are you or any adults in the home unemployed (not by choice)?	❑
Is the family experiencing financial problems?	❑

Please Take This Form

Warren Township Youth & Family Services

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include, but are not limited to, outpatient individual, family, and group psychotherapy.
- **Payment** means such activities as obtaining reimbursement for services and utilization review.
- **Health Care Operations** include the business aspects of running our agency, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

- We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state, or local law or to any law enforcement official for any circumstance required by law.
- We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
- We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.
- We will use and disclose as required by law any cases of suspected child abuse or neglect to the Illinois Department of Children and Family Services (DCFS) or its equivalent.

- We may disclose your PROTECTED HEALTH INFORMATION when the client is a minor and disclosure to the parent(s)/guardian(s) is in the client's best interests.
- In couple and family therapy/assessment, information disclosed by any family member without the other member(s) present may be disclosed to the absent members unless specifically prohibited.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Director at the agency address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

Revisions to our Notice of Privacy Practices will be posted on the effective date, and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Adam Krieger, Director
Warren Township Youth & Family Services
100 S. Greenleaf St.
Gurnee, IL 60031
(847) 244-1101, ext. *402

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(877) 696-6775 (toll-free)

Please Take This Form

WARREN TOWNSHIP YOUTH & FAMILY SERVICES
100 S. Greenleaf, Gurnee, IL 60031
Phone: (847) 244-1101 ext *401 - 24 hours Fax: (847) 244-0867
Email: youthservices@warrentownship.net
Website: www.wtyouthservices.com
Office Hours: M-Th (9:00am – 8:00pm) Friday (9:00am – 5:00pm) and Saturday as scheduled

Office Policies and Procedures

Services of Warren Township Youth Services (WTYS) are offered to children in birth-18 residing in Warren Township. Limited services are also provided to those over 18 years of age.

YOU HAVE THE **RIGHT** TO:

- Be treated in an ethical and professional manner.
- Confidential treatment. No information from outside sources will be requested or released without written consent. Exceptions to this are: (1) statistics required by funding sources; (2) information required by law (e.g. information about child/elder abuse or neglect); and (3) reporting of a person presenting a danger to self or to others.
- Review your clinical treatment records at WTYS.
- Refuse treatment.
- Freedom from abuse or neglect.
- Access to WTYS formal grievance procedure. Concerns should first be directed to the relevant staff person, then to his/her Supervisor. The Supervisor's decision on a grievance constitutes a final administrative decision.

YOU HAVE THE **RESPONSIBILITY** TO:

- Conduct yourself in a manner appropriate to a community setting and to respect personal, physical, and property rights of other clients and staff at WTYS.
- Use Warren Township emergency services only in case of genuine need.
- Be responsible for the behavior of your minor children brought to WTYS.
- Participate in individual treatment planning by the WTYS staff.
- Comply with physician's orders with regard to medication.
- Keep and observe all the laws of the local government, state, and nation while at WTYS.
- Keep scheduled appointments or cancel them within 24 hours.

SERVICES

Our services include individual, family, and group counseling. You and your therapist will determine what your meeting schedule will be. Sessions are between 45-60 minutes in duration, starting at the scheduled appointment time.

APPOINTMENTS

We realize that it is not always possible to keep an appointment. Since we do not double-book appointments, a 24-hour notice is expected in the event of cancellation. The time is set-aside for you alone. We care about the mental health of our clients but continually missed appointments take time away from other clients who want counseling. **In order to accommodate those clients on our waiting list, we may terminate our service to you if you have missed 2 appointments or we are unable to contact you.** Should you decide you want to continue, you will need to go through the process of an Intake.

CONTACTING YOUR THERAPIST

Should you need to contact your therapist, you may call the above number and leave a message with the secretary or on voicemail of the therapist. To contact your therapist directly, call 847-244-1101 ext. (*extension number). Your therapist will return your call as soon as possible. Most full-time therapists will

return calls only when they are in the office. If there is an urgent matter concerning life and death, please take your child directly to the emergency room or call 911.

EMERGENCY
If there is an emergency during regular hours, call the front desk to speak to your therapist or the director at 847-244-1101 ext. *401. In case of emergency during non-office hours, please take yourself or your child directly to the emergency room if it's a life threatening behavior. If you need to contact Youth Services after normal hours, you may call the on-call services **855-577-9360**.

Helplines

These are helplines that we have found to be responsive and professional. They provide help if you are in crisis, need information or want someone to talk to about a problem.

Youth Helplines—Any Youth related issues, particularly concerning Depression or Suicide
Boys Town Hotline… 1800-448-3000
National Hopeline… 1800-SUICIDE
Lake Count Mental Health… 847/377-8088
Text-A-Tip… Text LAKECO and a brief message to 274637

Drug and Alcohol Issues
National Alcohol Drug Abuse Hotline… 1800-784-6776
Alcoholic Anonymous (Chicagoland)… 1800-371-1475

Domestic Violence (Lake County)
A Safe Place… 847-249-4450

Runaways
National Runaway Switchboard… 1800-621-4000

Parenting Help
Boys Town Hotline… 1800-448-3000
Parental Stress Hotline… 1312-3PARENT

Sexual Abuse
Zacharias Center… 847-872-7799

Report Child Abuse
DCFS… 1800-252-2873

Medical/Psychiatric Assistance for Uninsured
Lake Count Mental Health… 847-360-6725

Other Important Contact_____
Phone _____

In case of a life threatening emergency, always call 911 or go directly to the hospital.

Active Clients can call the On Call staff person or leave a message for their therapist if the matter is not life threatening. The on-call number is 855-577-9360.

AK/Updated 2/20/2017