435 W. Washington St.
Springfield, IL 62702
E. Thrive@thrivecenterforwellness.com
P. 217.203.6600
W. www.thrivecenterforwellness.com

Patient Information

Printed Name: _____

Date of Birth: _____

Mailing Address: _____

Telephone Number: _____

Email Address: _____

Reason for Visit: _____

_____

_____

Emergency Contact – Name / Relationship: _____

Telephone number: _____

Insurance Carrier/EPA Provider:_____

Policy Number: _____

Group Number: _____

How did you hear about Thrive Center for Wellness? _____

_____

_____

Patient Signature: _____ Date:_____

Staff Signature:_____ Date:_____

Cancellation Policy

Any cancellation of services requires a 24-hour notice. If you are unable to call at least 24 hours before your appointment or if you do not show up for a scheduled appointment, Thrive Center for Wellness reserves the right to charge half of the normal rate for reimbursement.

If you have an emergency prior to your appointment and cannot make it, please call Thrive Center for Wellness as soon as possible to speak with a member of your treatment team.

Emergency appointments are based on availability. Emergency appointments are billed at an additional $50.00 in addition to the current, regular fee.

_____

Patient Signature _____Date

_____ _____Date

Witness Signature

Fee Payment Policy

Co-Payments and Self-Payments are due at the time of service. If you cannot pay or payment arrangements were made prior to your appointment, your appointment will be rescheduled and may be subject to additional fees as noted in the *Cancellation Policy.*

_____Patient Signature _____ Date

_____Witness Signature _____ Date

Attendance Policy

Thrive Center for Wellness understands life situations happen. It is important to your health and successful completion of our program that you attend all scheduled appointments and group meetings. It is your responsibility to know any appointment dates and times.

I understand that I maybe subjected to a "No Show" fee for breaking my agreement to attend appointments as scheduled, if that should occur.

Thrive Center for Wellness considered two (2) cancelations or no shows within 30 days to be extreme. If you miss three (3) appointments, you may be asked to attend a meeting with your treatment team to determine eligibility and the appropriate level of care.

_____ Patient's Signature _____ Date

_____ Witness _____ Date

SUBSTANCE USE SCREENS

Thrive Center for Wellness utilizes urine toxicology screens (rapid and laboratory) as well as breath alcohol tests to monitor compliance of abstinence during treatment. Lab screens are also utilized to ensure medicine compliance while receiving services

I am requesting treatment and I am authorizing Thrive Center for Wellness to administer routine services such as, but not limited to, the observed collection and testing of urine and other procedures necessary by those providing care and for which I voice no specific objection. By signing below, you are acknowledging and giving consent for Thrive Center for Wellness to conduct random urine toxicology screens and breath alcohol testing as a part of your treatment.

_____ Patient Signature _____ Date

_____ Witness Signature _____ Date

INSURANCE BILLING

Thrive Center for Wellness (Thrive) may bill your insurance company, when applicable, if professional services rendered are covered by your insurance company. Thrive staff will contact your insurance company to obtain coverage information from your insurance company to ensure services provided will be reimbursed. If your insurance company does not provide coverage for services provided, the fees will be charged to you, not the insurance company.

Payment in full for services is expected at the time treatment begins. Thrive fees are fair and reasonable but if you have any questions, Thrive staff will be glad to answer any questions you may have regarding payments. Even if a payment plan is established, the entire amount for treatment is due whether you entirely complete treatment or terminate services.

It is also important to know should you choose to submit a claim to your insurance company it may impact your ability to acquire life or health insurance in the future.

I have read and understand the disclosed information concerning insurance and payment issues. I agree to be responsible for payment in full for treatment whether I finish or chose to terminate services.

_____

Guardian Signature/Date

_____

Witness Signature/Date

_____

Statement of Patient Rights

You shall have the right to obtain/receive quality treatment and services at Thrive Center for Wellness regardless of race, religion, sex, culture, age, emotional disability, physical disability, sexual orientation or HIV status. You

also have the right to:

1. Humane, compassionate treatment and respect for my personal dignity and individual experience.
2. Have services provided in the least restrictive environment available.
3. Have your needs and problems addressed.
4. Develop and revise an individualized treatment plan with your primary counselor.
5. Participate in your discharge planning and continued care planning.
6. Receive current information concerning your diagnosis, treatment plan, and prognosis in a language you can understand.
7. Be treated with the highest quality and with equity regardless of the source of payment for services.
8. Confidentiality of HIV/AIDS testing.
9. Access legal counsel, or obtain a consultant, at your expense.
10. Review and receive a copy of the HIPAA Notification of Privacy.
11. Confidentiality. No communication shall be made to non-treatment center staff regarding your presence or progress in treatment without your expressed written consent.
12. Refuse treatment or any specified treatment procedure and a right to be informed of the consequences resulting from such refusal.
13. Receive from staff the names of alternate resources in the Central Illinois area.
14. Request a review of my Protected Health Information if I don't agree with a treatment decision. I may request an in-house review or obtain a consultant at my own expense.
15. Express a grievance or complaint related to any aspect of your treatment at Thrive Center for Wellness. Grievances of a serious nature can be taken to the facility's director.
16. Consult with a financial counselor at Thrive Center for Wellness regarding the cost of services.

On my own will, I am requesting and consenting to participation and/or admission into Thrive Center for Wellness for any of the following services: Assessment, Individual Therapy, Couples Therapy, Family Therapy, Group Therapy, Risk Education, Medically Assisted Recovery, Medicine management or titration, DUI treatment and/or diagnostic and therapeutic care. By signing this form, I am requesting treatment and I am authorizing Thrive Center for Wellness to administer routine services and other procedures necessary by those providing care and for which I voice no specific objection. My signature below indicates that I have read and understand my rights as a patient at Thrive Center for Wellness. I also realize that I will be solely responsible for any continual or periodic course of care that my counselor recommends should I decide to receive treatment.

Patient Signature/Date | Guardian Signature/Date | Witness Signature/Date

THRIVE
CENTER FOR WELLNESS

Acknowledgment of Informed Consent

I understand that information about my treatment and communications with my therapist may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission, as explained below:

1. If necessary, to protect my safety or the safety of others.

    a. If I am clearly a danger to myself, my therapist may take steps to seek involuntary hospitalization and may also contact members of my family or others.

    b. If I threaten to harm or kill someone and my therapist believes I may carry out my threat or if my therapist believes I will attempt to seriously injure or kill someone, my therapist may:

    - Tell any reasonably identified victim
    - Notify the police
    - Arrange for me to be hospitalized.

2. If necessary, to hospitalize me for psychiatric care.

3. If my therapist believes a child, disabled person, or an elderly person in my care is suffering abuse or neglect.

4. To provide information regarding my diagnosis, prognosis and course of treatment, or for the purposes of utilization review or quality assurance, to a third-party payer *(referring to communication with insurance companies and other medical providers).*

5. In legal proceeding where I introduce my medical or emotional condition.

6. *For individuals consenting to DUI services only*: Organizations providing a DUI evaluation or risk education intervention services shall disclose offender information as allowed by law. This includes allowing for the disclosure of evaluation and risk education to Illinois court officials, the Illinois Office of the Secretary of State, and other interested departments of the State of Illinois for the purpose of adjudicating and court monitoring of DUI cases, drivers' license issues, and for monitoring licensed services.

Additionally, I authorize my therapist to consult professional colleagues if needed to enhance the clinical services I receive.

I have had the opportunity to discuss this informed consent statement with my therapist. I understand its meaning and consent to receiving services based on this understanding.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, which is information about you, including demographic information, that may identify you and that relates to your past, present or future mental health and related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by our organization, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing mental health care services to you, to pay your mental health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use or disclose your PHI to provide, coordinate, or manage your mental health care and related services, including the coordination or management of your care with a third party. For example, your PHI may be provided to a physician who referred you to ensure that the physician has the necessary information to treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your mental health care services. For example, your relevant PHI may be disclosed to your health insurance provider to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. For example, we may call you by name while you are at our facility, and we may disclose your PHI to accrediting agencies as part of an accreditation survey.

We may use or disclose your PHI in the following situation without your authorization: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance with its requirements.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your therapist or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your PHI:

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. **You have the right to request a restriction of your PHI.** You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you request. If our organization believes it is in your best interest to permit use and disclosure of you PHI, your PHI will not be restricted. You then have the right to use another healthcare professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically. You may have the right to have our organization amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice. Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying the director of Thrive Center for Wellness of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any questions concerning or objections to this form, please ask to speak with the director of Thrive Center for Wellness. Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No mental health care information is provided. We welcome your comments and questions. Please feel free to speak to us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

I acknowledge that I was provided with a copy of the Notice of Privacy Practices INITIAL_____

Printed name of Patient or Guardian/Representative and Relationship to Patient_____ Date _____

Signature of Patient or Guardian/Representative _____ Date _____

Tele mental Health Informed Consent

I _____, (name of client) hereby consent to

participate in tele mental health with _____ (Thrive Center for Wellness) as part of my psychotherapy. I understand that tele mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to tele mental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risk and consequences associated with tele mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a tele mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call to discuss, since we may have to re-schedule.

) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian Date _____

Signature of therapist Date _____

Release Of Information

Authorization for Use / Disclosure of Health Information: I, _____, date of birth _____, voluntarily consent to authorize Thrive Center for Wellness to use or disclose my health information during the term of this Authorization to the recipients that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____

Purpose: I authorize the release of my health information for the following specific purpose: _____

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be Disclosed: I authorize the release of the following information: (check the applicable box below)

□ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received.

□ On the following records or types of health information: _____

_____

Term: I understand that this Authorization will remain in effect: (check the applicable box below)

□ From the date of this Authorization until the _____

□ Until the Provider fulfills this request.

Refusal to Sign / Right to Revoke: I understand that signing this form is voluntary and that if I do not sign, it will not affect the commencement, continuation, or quality of my treatment at Thrive Center for Wellness. If I change my mind about granting the Authorization, I understand that I can revoke it by providing ***written notice*** of revocation to Thrive Center for Wellness. The revocation will be effective immediately upon my heath care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before he/she received my written notice of revocation.

_____ _____

Patient Signature Date Witness Signature

If the individual is a minor or unable to sign this Authorization, please complete the information below:

_____ _____

Name of Guardian / Representative Date Witness Signature