Correspondence Address

501 W Ogden Ave, Ste 1, Hinsdale, IL 60521
1S376 Summit Ave Court D, Unit 5 B Oak Brook Terrace, Il 60181
WWW.ABCDUPAGE.com

(630) 986-0599 (Hinsdale)
(630-629-6550 (Oak Brook Terrace)
(630) 986-1477(FAX)

Dear New Client:

Welcome, and thank you for choosing us to help you on your healing journey.

Your work is just beginning. Filling out the enclosed forms before coming to your first appointment allows your therapist to use your time wisely. Please either bring all the forms with you to your first session, so that we may enter you information into our system.

1. **Billing Insurance Registration**: We need this information from you for billing and audits. Please bring your insurance card in with you so we can make a copy for our records.
2. **Therapy Service Agreement**: Two copies. One is yours to keep. Please read through this carefully. If you have any questions, please feel free to ask your therapist, they can help you understand the contents of the agreement.
3. Copies of our HIPPA Privacy notice is available upon request from our HIPPA privacy officer. Please contact our office to request.

We are in-network providers for most major insurance companies. As a courtesy to you, we work directly with your insurance and will make every effort possible to bill your insurance company.

In compliance with health insurance contracts, Advanced Behavioral Centers of Dupage requires that all copayments are collected for payment at the time of service and that all coinsurance and deductible amounts are collected immediately following insurance claim processing. Please make sure that you are prepared to make payment for your copayment via (check/money order or credit card via a reoccurring authorization form attached) We do not have the ability to waive copayments, deductibles, or coinsurance amounts due, as this is a violation of the contract we have with your insurance company.

Please be on time for your appointment. This is ***your*** time.

Sincerely,

REGISTRATION FORM

Instructions: Please fill out this form and make a copy of the front and back of your insurance card and attach it. Please complete a copy of this form for each family member being seen. Please fax the form(s) back to (630)986-1477.

CLIENT INFORMATION - DETAILS OF THE PERSON BEING SEEN

Client's last name:	First:	Middle:	○ Mr. ○ Mrs.	○ Miss ○ Ms.	Marital status: Single ○ Married ○ Divorced ○ Separated ○ Widowed ○

Is this your legal name? Yes ○ No ○	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ○ M ○ F

Street address:	Social Security no.:	Home phone no.: Cell phone no.:

P.O. box:	City:	State:	ZIP Code:

E-Mail Address:	Employer:	Employer phone no:

INSURANCE INFORMATION - DETAILS OF THE PERSON RESPONSIBLE FOR THE BILL = THE INSURED

(Please give your insurance card to your Therapist.)

Person responsible for bill:	**Birth date:**	Address: street/city/state/zip (of person responsible for bill):	Home phone no.: Cell phone no.:

Occupation:	Employer:	Employer address: street/city/state/zip:	Employer phone no.:

Primary Insured's name:	**Primary Insured's S.S. no.:**	**Primary Birth date:**	**Group no.:**	**Subscriber ID:**

Primary Adress: street/city/state/zip	**Co- payment / Deductible:**	**EAP / TriCare Authorization Number:**

Insurance Company Name:	Billing Address:
Billing Address Cont.:	Insurance phone no.:

Client's relationship to Insured:	○ Self	○ Spouse	○ Child	○ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Client:	Home phone no.:	Work phone no.:

I permit Advanced Behavioral Centers of Dupage and billing staff to send the required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that I will be responsible for any unpaid balance such as copays, deductibles, and non-covered services**. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at $60.00**. I understand that neither my insurance nor EAP covers the cost of missed sessions. I understand that my therapist may not be able to schedule further sessions until all unpaid balances, such as copays due, are paid in full.

In consideration of services to be provided to me or my dependent, I hereby assign, transfer, and set over to Advanced Behavioral Centers of Dupage all of rights, title and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits. I understand that I am financially responsible to Advanced Behavioral Centers of Dupage for charges not covered by this assignment.

______________________________ Client /Guardian Signature

______________________________ DATE

CLIENT COUNSELING, THERAPY MEDICATION MANAGEMENT SERVICE AGREEMENT

Hinsdale (Office)

501 W. Ogden Ave, Ste 1

Hinsdale, IL 60521

Oak Brook Terrace (office)

1S 376 Summit Avenue, Court D, Unit 5B

Oak Brook Terrace, IL 60181

Please read and sign two copies of this agreement. Keep one copy for your records.

Advanced Behavioral Centers of Dupage is a business facility where many mental health professionals practice. Your contract for services is with Advanced Behavioral Centers of Dupage and all therapists who practice at Advanced Behavioral Centers of Dupage. Your therapy will be handled by your therapist or medication management provider, although your treatment may be discussed with other providers at Advanced Behavioral Centers of Dupage. If for any reason, you wish to change to a different therapist practicing at Advanced Behavioral Centers of Dupage, please contact Advanced Behavioral Centers of Dupage with this request.

Rights and Risks: Please feel free to ask questions about any aspect of the counseling process. · If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report. ·You need to be willing to discuss what troubles you and be open to change. · As a result of counseling, you may remember unpleasant events, arouse intense emotions, and/ or alter close relationships.

Confidentiality: Confidential Information shared will be held in confidence in compliance with applicable state and federal law. "Confidential Information" includes any recordings or transcripts of therapy sessions, therapist notes, medical reports or therapy progress reports. · Information will not be released without your written consent, except for professional consultation if needed or if the disclosure is required by law. · Your provider may be required by law to disclose information pertaining to suspected child abuse; inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others. · Should your therapy be involved or be the subject of court proceedings or litigation, your counseling records may be subject to subpoena. · It is understood that information regarding treatment and diagnosis may be provided to an insurance company. · You may want to discuss further limits or exceptions of confidentiality. · Information regarding your counseling, therapy and or medication managment will be used internally by Advanced Behavioral Centers of Dupage for the purposes of coordination and supervision, and will not be released to any third party without your express written release.

Client Agrees to: ☐ Allow **the therapist to be assisted by a co-therapist if either or both deems it appropriate.**

> **Note on Privacy**: I understand that the counseling sessions in which I participate with a co-therapist are for the purpose of improving my care. I understand that confidential information will be shared between my therapists and any co-therapists involved and I hereby authorize such disclosure.

Appointments: All office visits are by appointment with your therapist directly. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 60 minutes. · Late cancellation (less than 24 hours before) and/or no-show appointments are billed to the client for the full amount. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get the voice mail or our answering service. If your appointment is canceled or missed, contact reception staff for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

Fees:

The client portion (co-pay or full amount) of fees is expected at the time of service. · Your health insurance may help you recover some of your counseling costs. Please verify with your insurance company the amounts of coverage for outpatient psychotherapy by licensed professionals. If your policy requires pre-authorization to receive services, this is your responsibility and needs to be handled before your first visit.

Uninsured clients are expected to pay their fees as services are rendered. If required, ABC will fill out and submit forms to your insurance company. Otherwise, Advanced Behavioral Centers of Dupage will provide you with whatever forms and assistance available to help you receive the benefits to which you are entitled. This office will not accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. **Clients are responsible for payment (and insurance claims) on their accounts.**

Failure to pay your part may jeopardize your benefits. Copays are not negotiable. Clients paying on a cash basis and not billing any insurance company are expected to pay in full at the time of service unless a payment plan has been previously arranged. Except in the case of minors or when other arrangements are made, the person receiving the counseling service or medication management is financially liable. Accounts become delinquent after thirty (30) days. Delinquent accounts may be turned over for collection. Clients agree that they will be responsible for any collection/legal fees associated with collection efforts.

If for any reason your insurance company does not make a complete payment to Advanced Behavioral Centers of Dupage within **30** days of my office visit, I understand that I will be sent a bill explaining my amount due. If I do not submit payment to The Advanced Behavioral Centers of Dupage within the following **10** calendar days, **I hereby authorize you to debit my credit card (on-file) for the total amount due.**

In the event that the Insurance Company denies payment or applies the visit charge to my deductible, I understand that I am responsible for the amount billed by The Advanced Behavioral Centers of Dupage. As we are a <u>fee for service</u> Counseling Center the balance of your bill is due in full immediately, **I hereby authorize you to debit my credit card for the total amount due.**

I understand that should my credit card on file not be approved, I am still fully responsible for payment. I understand that if I fail to make any of the payments for which I am responsible promptly, I will be charged a 1.5% service charge monthly on the remaining balance. I further understand that if my account is not paid in full within 30 days, my account may be turned over for collections and I will be responsible for all costs of collection and monies owed, including court costs, collection and attorney fees.

If I cancel an appointment within 24-hours of my appointment start time, or fail to attend a scheduled appointment, I hereby authorize Advanced Behavioral Centers of Dupage to charge to my credit card the cancellation or missed appointment fee in the amount of $60. I authorize my credit card to be charged for patient balances pursuant to the above signed agreement.

Returned Checks: If I write a check that I have written to The Advanced Behavioral Centers of Dupage is returned, I hereby authorize you to debit my credit card for the total amount due plus and administrative fee for of $40.00. After that, any account balances must be paid by credit card, cash, or a money order.

Phone calls over five (5) minutes will be billed in 15 minute increments, at $30 per 15 minutes. This will not be processed by insurance (if the insurance company does not cover phone sessions) and will be owed from the client to Advanced Behavioral Centers of Dupage.

I will discuss any change in my financial situation with my therapist. I have read, understand and agree to the above policies. I have discussed these policies with my therapist (if desired) and all of my questions have been answered to my satisfaction. I have been offered a copy of these policies to take with me if I desired. I hereby authorize Advanced Behavioral Centers of Dupage and my therapist to release to my insurance company any information acquired in the course of my therapy (if client is a minor, by signing this agreement I certify that I am the parent or guardian of the minor child and authorize this release). I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred. I understand that in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred by or on account of the client named below and hereby assign Advanced Behavioral Centers of Dupage and all Insurance benefits due to me to the full extent of my financial obligation to Advanced Behavioral Centers of Dupage. I have read and/or received a copy of Advanced Behavioral Centers of Dupage Privacy Policy. If conjoint (couple or family) all adults need to sign this contract because of confidentiality and our rights, even though one person is the identified patient.

Psychiatrist/Nurse Practitioner			Price	
Insurance Code	Descripton	Unit	M.D	ARPN
90792	Initial Intake Med Interview/Assessment	60 min	$350.00	$ 200.00
99201	New Patient- 10 Min. E&M	10 minutes	$135.00	$ 100.00
99202	New Patient- 20 Min. E&M	20 minutes	$120.00	$ 150.00
99203	New Patient- 30 Min. E&M	30 minutes	$175.00	N/A
99204	New Patient- 40 Min. E&M	40 minutes	$250.00	N/A
99205	New Patient- 50 Min. E&M	50 minutes	$400.00	N/A
99211	Est Visti- 5 Min. E&M	5 minutes	$50.00	$ 50.00
99212	Est Visti- 10 Min. E&M	10 minutes	$100.00	$ 100.00
99213	Est Visti- 15 Min. E&M	15 minutes	$125.00	$ 125.00
99214	Est Visti- 25 Min. E&M	25 minutes	$175.00	$ 175.00
99215	Est Visti- 40 Min. E&M	40 minutes	$225.00	N/A
90833	Add on Psychotherapy	30	$125.00	$ 125.00
90836	Add on Psychotherapy	45	$185.00	$ 185.00
90838	Add on Psychotherapy	60	$250.00	$ 250.00
Not Billable to Insurance	Missed Appointment	Any	$60.00	$ 60.00
Not Billable to Insurance	Late Cancel <24 hrs	< 24 hrs	$30.00	$ 30.00
Not Billable to Insurance	Fees, Phone calls, Letters, & Reports	5-15 min increments	$30.00	$ 30.00
Not Billable to Insurance	Phone/Video Therapy	15 minutes	$50.00	$ 40.00
Not Billable to Insurance	Court Appearances	45-50 minutes	$250.00	$ 250.00
Not Billable to Insurance	Copy Records Fee	1 unit	$25.00	$ 25.00

Therapist			Price	
Insurance Code	Descripton	Unit	Psychologist	Masters
90791	Initial Intake Interview/Assessment	un-timed	$250.00	$ 200.00
90832	Counseling sessions	16-37 min	$135.00	$ 100.00
90834	Counseling sessions	38-52 min	$120.00	$ 150.00
90837	Counseling Sessions	53+ min	$225.00	$ 175.00
96101	Psych Testing	60min	$250.00	N/A
90785	Interactive Complexity	1 unit	$15.00	$ 15.00
Not Billable to Insurance	Missed Appointment	Any	$60.00	$ 60.00
Not Billable to Insurance	Late Cancel <24 hrs	< 24 hrs	$30.00	$ 30.00
Not Billable to Insurance	Fees, Phone calls, Letters, & Reports	5-15 min increments	$30.00	$ 30.00
Not Billable to Insurance	Phone/Video Therapy	15 minutes	$50.00	$ 40.00
Not Billable to Insurance	Court Appearances	45-50 minutes	$250.00	$ 250.00
Not Billable to Insurance	Copy Records Fee	1 unit	$25.00	$ 25.00

E–MAILS, CELL PHONES, TEXTS, COMPUTERS, AND FAXES: Computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and therefore can compromise the privacy and confidentiality of the information used in such communications. Servers and telecommunication companies often have direct and unlimited access to all the information contained in the e-mails, texts and e-faxes that use their services. Advanced Behavioral Centers of Dupage computers utilize virus protection software and a password. Advanced Behavioral Centers of Dupage Electronic medical records system also backs up all client related information on a regular basis. When you communicate with your therapist or medication management provider using unencrypted e-mail, texts or e-fax or via phone messages, you assume the responsibility of the risk that your information and identity may be intercepted. If you choose to communicate with your therapist or medication management using e-mail or SMS/text messaging, you are advised to use personal email and SMS/MMS addresses rather than those associated you're your work accounts. Please do not use texts, e-mail, voice mail, or faxes for emergencies as they will not be accessed in a timely manner.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of Advanced Behavioral Centers of Dupage require that we keep treatment records for at least 7 years unless legally required to maintain for a longer period. Please note that clinically relevant information from emails, texts, and faxes are part of the clinical records. If you have concerns regarding the treatment records, please discuss them with your therapist or medication management provider. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when therapist or medication management provider assesses that releasing such information might be harmful in any way. In such a case your therapist or medication management provider will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, your therapist or medication management provider will release information to any agency/person you specify unless therapist or medication management provider assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, therapist or medication management provider will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

SOCIAL MEDIA POLICY: Advanced Behavioral Centers of Dupage and your therapist or medication management provider takes issues of confidentiality and privacy, as well as healthy boundaries relating to the therapeutic relationship, very seriously. To protect the right of client and therapist for privacy, to safeguard the confidentiality of information shared between them, and in order to avoid confusion and maintain clear boundaries between client and therapist, (therapist's name) has chosen to follow these principles concerning the use of social media:

- Your therapist or medication management provider does not engage with clients in any way on social networking sites. For example, friend requests on Facebook will be denied and any communication on social platforms such as Messenger, will be ignored.
- If your therapist or medication management provider has an active Facebook page as part of a professional practice, which aims to share updates and blog posts. Clients are welcome to view and share the posts but they will not be able to become fans of that page.
- If your therapist or medication management provider has an active Twitter account used to publish clinical news. Clients are not expected to follow this account. While clients have the right to follow any twitter account they wish, they should consider safer options (such as using an RSS feed or a locked Twitter list). (Therapist's name) does not follow past or current clients on Twitter.
- The preferred method to contact with your therapist or medication management between sessions is the phone. This is especially true when a client wishes to discuss therapeutic related issues. .
- For brief pragmatic communications, such as rescheduling a session, clients may also use email. To protect your information, please avoid using email to communicate matters related to the sessions.

- Avoid using SMS (mobile phone text messaging) or messaging through Social Networking sites (WhatsApp, Messenger, etc.) to contact (therapist's name).
- Your therapist or medication management provider will not be able to see materials clients post on social media but if they wish to bring something relevant to the treatment or otherwise to the session, they are welcome to do so.

AUDIO OR VIDEO RECORDING: Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided by therapist or medication management provider.

TERMINATION: As set forth above, after the first couple of meetings, your therapist or medication management provider will assess if he can be of benefit to you. Your therapist or medication management provider does not work with clients who, in his/her opinion, he/she cannot help. In such a case, if appropriate, he will give you referrals that you can contact. If at any point during psychotherapy your therapist or medication management provider either assesses that he is not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, he will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, he would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, Your therapist or medication management provider will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist Your therapist or medication management provider will give you a couple of referrals that you may want to contact, and if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, Your therapist or medication management provider will provide you with names of other qualified professionals whose services you might prefer.

I acknowledge I have received, read and understand The Advanced Behavioral Centers of CLIENT COUNSELING, THERAPY MEDICATION MANAGEMENT SERVICE AGREEMENT

By signing below, I agree to the terms of the agreement:

Client's Name (print) ____

Signature ____ Date ____________________

Client's Name (print) ____

Signature ____ Date ____________________

Please Initial One

Recurring Authorization:	
Update Information:	
Cancel Authorization:	

Credit Card/ACH Payment Authorization Form

Name of Person authorizing payment:		
Name of business (if Applicable and hereafter "Accountholder")		
Address:		
City:	State:	Zip:

Credit Card type (please check one)	MC		VISA		Discover		AMEX	
Credit Card Number: MasterCard, or Visa, or Discover	Master, Visa or Discover Card here (no spaces or hyphen)							
Expiration Date (MM/YY)	/				VID CODE (3-digit on Back)			
Credit Card Number: American Express:	American Express here (no spaces or hyphen)							
Expiration Date (MM/YY)	/				VID CODE (4-digit on Front)			

Checking (Check one)		Savings (Check one)		**Please Attach a Voided Check**
Routing Number:				Bank Transit/ABA No.
Financial Institution Name				City ,State, Zip Code

By completing and executing this form, the cardholder acknowledges and agrees that Advanced Behavioral Centers of Dupage LLC (hereafter "Company) is authorized as of the authorization date set forth below and subject to the terms and conditions set forth below, to charge the credit card, debit card, chard card, electronic check draft (ACH) or other payment card (each referred to herein as "Credit Card" or Check), specified above for the amounts billed to the accountholder or the card holder specified above for service rendered.

Company will send the accountholder or cardholder an invoice for service rendered. Company will charge the above credit card or ACH for the amount specified in the invoice on or around the date of the invoice. The account holder/credit card holder should ensure such charge will not cause the credit card account or ACH draft to exceed any established credit /bank limits or available balances as on the date of charge/draft. There will be a $25.00 penalty for any rejected charge pursuant to this authorization. Cardholder acknowledges that they will continue to be liable for any such rejected or any unpaid charges including all penalties and legal fees. Cardholder further authorizes Company to initiate a chard or credit as necessary to correct any prior overpayment or underpayment of any invoice or any other charge or credit effected under this or prior authorization(s) Company and cardholder further acknowledge that if this payment authorization is for a recurring charge/ draft, then Company will inform cardholder of any variances in the recurring amount. Each charge will appear as a payment on the next invoice sent to accountholder/cardholder after the charge date. All charges and ACH debits will appear as Advanced Behavioral Centers of Dupage LLC.

To Update/Cancel the above credit card information, please execute this form and check "Update information" or "Cancel authorization and fax back to number provided below. This authorization shall remain in effect until Advanced Behavioral Centers of Dupage LLC, receives a new form requesting an update or cancellation, and the Advanced Behavioral Centers of Dupage LLC has had sufficient time to clear any arrears and act on the authorization. Cardholder will continue to be liable for any invoices due and pending as of such termination. Cardholder is responsible for informing Company of and any changes in the above information.

If you have any question on billing or credit card/ACH charges please contact our correspondence address, Advanced Behavioral Centers of Dupage LLC 501 W Ogden Aver, Ste 1, Hinsdale Il, 60521

Signature of Cardholder/Accountholder:
Authorization Date:

HIPAA Privacy Policy

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

I. Uses and Disclosures for Treatment. Payment. and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

"**PHI**' refers to information in your health record that could identify you.

"**Treatment, Payment, and Health Care Operations**"

– Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. Treatment includes consultation with another health care provider, such as your family physician or another therapist or psychiatrist.

– Payment is when we obtain reimbursement for health care services rendered. Payment includes disclosure of your PHI to your health insurer to obtain reimbursement for services or to determine eligibility or coverage.

– Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"**Use**" applies only to activities within our practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"**Disclosure**" applies to activities outside of our practice group such as releasing, transferring, or providing access to information about you to other parties.

"**Authorization**" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally-required form.

II. Other Uses and Disclosures Requiring Authorization:

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations with your authorization. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes that some providers choose to make about conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your record. These notes include recordings and transcripts of any therapy sessions. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have taken some action in reliance on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, as applicable state and federal law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse – If we have reasonable cause to believe a child known to us in our professional capacity may be an abused child or a neglected child, we must report this belief to the appropriate authorities.

Adult and Domestic Abuse – If we have reason to believe that an individual protected by state law has been abused, neglected, or financially exploited, we must report this belief to the appropriate authorities.

Health Oversight Activities – we may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

Worker's Compensation – we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is pursuant to court order. You will be informed in advance if this is the case.

Serious Threat to Health or Safety – If you communicate to us a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

IV. **Client's Rights and Behavioral Health Provider's Duties**

Client's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, we will discuss with you the details of the access process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. Upon request, we will discuss with you the amendment process.

Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

Right to a Paper Copy - You have the right to obtain a paper copy of this notice from us upon request.

Behavior Health Provider's Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

If we revise our policies and procedures, we will notify you in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision that your therapist makes about access to your records, or have concerns about your privacy rights, you may contact your therapist or Advanced Behavioral Centers of Dupage staff. If you believe that your privacy rights have been violated and wish to file a complaint against Advanced Behavioral Centers of Dupage, you may send your

written complaint to the Secretary of the U.S. Department of Health and Human Services. Advanced Behavioral Centers of Dupage can provide you with the appropriate address upon request. You have specific rights regarding the privacy and use of your PHI under federal law. Advanced Behavioral Centers of Dupage will not retaliate against you for exercising your right to file a complaint.

VI. **Effective Date, Restrictions, and Changes to Privacy Policy**.

This notice will go into effect on July 1, 2010. Advanced Behavioral Centers of Dupage reserves the right to change the terms of this notice and to make the new, notice provisions effective for all PHI that Advanced Behavioral Centers of Dupage maintains. Advanced Behavioral Centers of Dupage will provide you with a revised notice in person or by mail.

Advanced Behavioral Centers of Dupage
Corporate Office
501 W Odgen Ave
Suite 1
Hinsdale, Il 60521
Voice: 630-986-0599
Fax: 630-986-1477

ADVANCED BEHAVIORAL CENTERS OF DUPAGE ACKNOWLEDGEMENT OF THE HIPAA PRIVACY NOTICE

By signing below, I acknowledge that I was provided a copy of Advanced Behavioral Centers of Dupage's HIPAA Privacy

Print Patient Name: ____Date: ______________________.

Signature:____ Date:________________________