ADULT INTAKE INFORMATION

(To be completed by client prior to first visit)

SS#/ID# _____ **Date**_____

Name: _____**Age:** _____ **DOB:**_____

Mother's Maiden Name: _____

Client's address: _____

Street and mailing address

_____

City Zip Code County of Residence

Phone(home): _____ (work): _____

Phone(cell): _____ E-Mail _____

Primary mode of communication (please circle): ___ Sign ___ Written ___ Verbal: Language _____

Sex: M / F / T **Race:** _____ **Religion:** _____

Referral source: ____Employer ____Self ____DCFS ____Court Other: _____

Emergency Contact/Guardian: _____

Address: _____ Phone: _____

Marital Status (check which applies):

___Single ___Engaged ____Cohabitating (partner's name): _____ Length of time:_____

___Married (spouse's name): _____ Length of Time: _____

___Widowed ____Separated ____Divorced Other:__ _____ Length of Time:_____

If you are married, are you currently living with your spouse? _____

Please list first and last names of people living in your home (include yourself):

Adults: Age: Relationship:

_____

_____

_____

_____

Children (oldest to youngest): Age: Relationship: Grade in School:

_____

_____

_____

_____

_____

Years of education: _____ School presently attending: _____

School problems that may still impact your life: _____

_____

_____

Have you served in the military: ____Yes ____No Are you a veteran: ____Yes ____No

Occupation:_____

Employer: _____ Length of Employment:_____

Problems at work: _____

Please check any of the following that provide you with financial or medical assistance:

___SSI ___Trust beneficiary

___Social Security Disability ___Representative payee (specify):_____

___Public Aid ___Private insurance

___Medicare ___Unemployment

___Veterans Administration ___Township relief

___Office of Rehab Services ___Guardianship (specify): _____

___Disability pay Guardian's name:_____

___Public Aid Medical Card ___Food stamps

___Other Social Services_____

Annual household income (before taxes): _____

Why are you seeking counseling/therapy at this time and what do you hope to accomplish?

_____

_____

Please rate the **present** severity of your symptoms/problems by circling one of the following:

Mild Moderate Extreme Life Threatening

Current mental or physical health problems_____

_____

_____

Date of last physical exam: _____ Doctor's name:_____

Doctor's Address & Phone: _____

Pregnant: ____Yes ____No ___unsure ___N/A Doctor's name:_____

Do you need referrals for a doctor for yourself or other family members? ____Yes ____No

Please check any of the following that are of concern to you

_____ Depressed mood

_____ Tearfulness, crying

_____ Fatigue/Lack of energy

_____ Social withdrawal/isolation

_____ Diminished interest/pleasure in most activities

_____ Feelings of hopelessness

_____ Worthlessness or inappropriate guilt

_____ Diminished ability to concentrate, make decisions

_____ Neglect of critical role functions

_____ Recurrent suicidal thoughts, attempts/gestures

_____ Appetite or weight decrease/increase (unplanned)

_____ Hypersomnia

_____ Insomnia

_____ Labile/unstable mood

_____ Irritability

_____ Paranoia

_____ Impulsivity

_____ Decreased sleep

_____ Inflated self esteem

_____ More talkative than usual

_____ Racing thoughts

_____ Attention drawn to unimportant/irrelevant stimuli

_____ Psychomotor retardation or agitation

_____ Impulsive behaviors leading to negative consequences

_____ Anxious Mood

_____ Worry, excessive

_____ Panic, shortness of breath, palpitations, sweating

_____ Distractibility/poor concentration

_____ Hypersensitivity

_____ Restlessness

_____ Fears/Phobias

_____ Disturbed sleep

_____ Intrusive repetitive disturbing thoughts/images/impulses

_____ Feeling compelled to engage in repetitive acts or rituals

_____ Exaggerated startle response

_____ Hypervigilance

_____ Anger outbursts/loss of temper

_____ Physical aggression/assaults

_____ Restricting food intake, binging/purging

_____ Self mutilation/cutting

_____ Shoplifting/theft

_____ Distrust/suspiciousness of others

_____ Detachment from social relationships

_____ Restricted range of emotions

_____ Persistent feelings of emptiness

_____ Dramatic/exaggerated expression of emotions

_____ Confusion/Disorganized thinking or speech

_____ Racing thoughts

_____ Hallucinations, Auditory/Visual

_____ Irrationality/delusions

_____ Neglect of self-care skills, hygiene, grooming

_____ Social withdrawal/isolation

_____ Neglect of critical role functions

_____ Lack of motivation/avolition

_____ Flattened affect

Substance Abuse/MISA Cluster

_____ Tolerance/increased use

_____ Withdrawal

_____ Cravings

_____ Blackouts

_____ Seizures

_____ Delirium Tremens

Legal history: Number of arrests: _____

___Purse snatching	___Gang involvement	___Hate Crime
___Reckless driving	___Breaking and entering	___Mob Action
___Shoplifting	___Auto theft	___Grand theft
___Drug possession	___Drug sales	___Drug paraphernalia
___Rape	___Murder	___Burglary
___Fire setting	___DUI	___Vandalism
___Violence to siblings	___Violence to spouse	___Child Abuse/Neglect/Endangerment
___Violence to teachers	___Violence to parents	___Damage to property
___Violence to significant other	___Violence to animals	___Violence to peers

Explain (include description, where, when, consequences): _____

_____

_____

_____

Legal status:

Legal rights intact: ___Yes ___No Guardian: _____

Representative payee: _____

Court order pending: ____Yes ____No

Court Supervision/Probation/Parole/TASC (please circle) from_____ to _____

Probation/Parole/TASC officer: _____

Address: _____ Phone:_____

Do you have child care that will allow you to attend your counseling sessions: ____Yes ____No ____ N/A

If no, resources explored/referrals provided: Family _____ Friends_____

Day care facilities _____ DCFS_____ Other_____

Do you have a way to get to your counseling sessions: ____Yes ____No ____N/A

If no, resources explored/referrals provided: Family_____ Friends_____

CEFS_____ Hicks Medivan_____ Other: _____

Were you satisfied with the length of time between the time you called for an intake and the date you were first scheduled to be seen: ___Yes ___ No ___N/A Comment:_____

Thank you for taking the time to complete this questionnaire. Please return this to the front desk. Next you will see our Mental Health Billing Specialist to set your fee and then your therapist, counselor or case manager will be with you.

My signature below indicates that I have received a copy of the Client Rights, Responsibilities and Grievances Procedures. In doing so and in reading the Welcome to the Montgomery County Health Department letter, I have completed the first part of the Orientation Process.

_____ _____

Signature Date

_____ _____

Guardian Signature (if applicable) Date

Information within this questionnaire has been reviewed and discussed with the client. As well, I have further completed the Orientation Process with the client.

_____ _____

Signature and credentials of counselor/therapist/case manager Date

Rev. 02/12

AUTHORIZATION AND ASSIGNMENT

Please check one

_____ I hereby give authority to Montgomery County Health Department (MCHD) to furnish all information which my insurance company may request and need in connection with my illness and condition; at the same time, I give authority to the insurance company to make payable to MCHD any medical benefits which may be due to me under this policy as a result of my illness.

_____ I hereby choose to not have my services billed to my insurance company and agree to pay all costs myself or per other arrangements made with the financial department at MCHD.

I hereby authorize MCHD to examine any and all medical records maintained in connection with my treatment for any illness or condition, and to obtain copies of such records as my therapist/physician shall deem necessary.

If applicable, I authorize MCHD to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim. This information can contain but is not limited to my name and demographic information. I understand this information will be kept in my clinical record as well as the data base of the Department of Human Services. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or the party who accepts assignment.

I understand that MCHD does not accept responsibility for collection of my insurance benefits or negotiating the settlement of a disputed claim. I am responsible for the payment of all clinic charges regardless of anticipated insurance coverage, unless prearranged through employer or third party payee.

I understand that disclosure of my social security number is required pursuant to federal regulations 42 U.S.C. Section 405 (c) (2). I further understand that my social security number may be used for identification; determination of Medicaid and, for substance abuse clients, contract eligibility for services; accumulation of benefits across payers; and detection and possible prosecution of fraud.

I understand that MCHD uses Electronic Billing for Medicare, Blue Cross and Blue Shield and Illinois Department of Public Aid. Therefore, I understand if I carry any of these insurances that my claims will be submitted electronically. Although I have requested the Health Department to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid within a reasonable amount of time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangement for prompt payment of the bill.

SIGNATURE_____ DATE _____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST SO THAT WE MAY MAKE A COPY OF YOUR CARD FOR OUR RECORDS.

Revised 04/10

MONTGOMERY COUNTY HEALTH DEPARTMENT
DIVISION OF MENTAL HEALTH
AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby authorize the use or disclosure of protected health information about me as described below:

_____ I hereby authorize:
_____
_____
_____
_____

_____ I hereby authorize:
Montgomery County Health Dept
Division of Mental Health
11191 IL. Rt. 185
Hillsboro, IL 62049

To release to:
Montgomery County Health Dept
Division of Mental Health
11191 IL Rt. 185
Hillsboro, IL 62049

To release to:
_____
_____
_____
_____

The following information: (Initial items wanted, cross out items not wanted, or write in items)
Blanket consent for unspecified information shall not be valid [740 ILCS 110/5 c]

_____Summary of contacts
_____Psychiatrist Notes
_____Psychological report
_____ Mental Health Assessment
_____ Treatment Plan
_____Discharge summary
_____Other
_____
_____
_____

_____Copy of evaluation
_____Therapist/Counselor/Case Manager notes
_____Legal history
_____Health history
_____Driving record
_____Substance use/abuse history
_____Compliance with tx recommendations

_____ Copy of records only
_____ Access to review chart only
From (date): _____ **To (date): _____** (Must be actual dates of the records)

Must mark one.

For the purpose of:

_____Transfer of treatment to another agency, facility or person
_____Consultation with other persons participating in the treatment process
_____Court testimony
_____At the request of the client/parent/guardian
_____Other (**specify**)_____

(Only one client per form)

Regarding: Name:_____ DOB: _____

Address:_____ Chart #:_____
_____

I understand that:

1. My records cannot be released without my permission in writing except in cases of suspected child abuse/neglect, cases of imminent harm to yourself or others, or in the communication with care givers.
2. I understand that I may revoke this authorization by notifying the Montgomery County Health Dept. in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have an affect on actions already taken by the Montgomery County Health Dept. in reliance on this authorization.
3. This release is invalid if I am acutely impaired by a mood altering substance.
4. I understand that information released by the Montgomery County Health Department is no longer covered by HIPAA rules and may be re-released by the recipient.
5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits
6. Consequences of refusing to consent to this authorization are:
   - No release of information
7. I must pay a fee for making copies of my records for personal use. These costs are:
   92 cents for the 1st through 25th pages
   61 cents for the 26th through 50th pages
   31 cents for all pages in excess of 50
   (Plus postage where applicable)

This consent is valid until (Check and complete one):

_____ _____, 20_____.

OR

_____ On the happening of the following event that relates to me or the purpose of the use or disclosure:_____

_____

_____

This form has to be fully completed before signing. Non-complete forms will be returned.

_____ _____

Signature of Client Date

_____ _____

Signature of Client's Representative (if under 18) Date

_____

Description of Client's Representative, if applicable

_____ _____

Witness Signature Date

A copy of this fully completed and signed must be given to the client.

NOTICE TO REVEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health & Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. Under the Federal Act of July 1, 1975 Confidentiality of Alcohol and Drug Abuse Patients Records, no such records, nor ay information from such records may be further disclosed without specific authorization for such a re-disclosure.

7/03 – Revised – MCHD, 8/07,6-08,11/10

Montgomery County Health Department - Division of Mental Health

CLIENT RIGHTS, RESPONSIBILITIES AND GRIEVANCE PROCEDURE

The client's right shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (405 ILCS 5). All appropriate records kept at the Montgomery County Health Department are subject to the Freedom of Information Act (5U.S.C. 552).

MISSION STATEMENT: The Montgomery County Health Department- Division of Mental Health, operates to provide professional, confidential services to persons experiencing symptoms of a mental health or substance abuse disorder, as well as, educate the community to promote a better understanding of such symptoms. These services are available to all persons regardless of race, color, creed, religious affiliation and/or spirituality, age, gender, sexual orientation or ability to pay.

CLIENT RIGHTS:

The staff at Montgomery County Health Department wants you to know that your rights are important to us. Our goal is to provide quality services that respect the rights and dignity of the recipients. Receiving services here does not affect your legal rights in any way. As service providers we will work to protect your rights which include the following:

- To have access to services that will not be denied on the basis of race, color, creed, religious affiliation and/or spirituality, age, gender, sexual orientation or ability to pay.
- To have services provided in the least restrictive environment available.
- To confidentiality regarding HIV/AIDS status and testing as governed by the AIDS Confidentiality Act [410 ILCS 305] and the AIDS Confidentiality and Testing Code (77 Ill Adm Code 697).
- To nondiscriminatory access to services as specified in the Americans With Disabilities Act of 1990 (42 USC 12101).
- To receive confidential services as governed by the Confidentiality Act of Alcohol and Drug Abuse Patient Records regulations (42 CFR 2(1987)), of the Alcohol, Drug Abuse and Mental Health Administration, of the Public Health Service, of the United States Department of Health and Human Services and the Mental Health, of the Developmental Disabilities Confidentiality Act [740 ILCS 110] and the Health Insurance Portability and Accountability Act of 1996 [42 U.S.C. & 1320dd2]. Only in cases of suspected child abuse/neglect, in cases of imminent harm to yourself or someone else, or in the case of necessary communication with parents of minor children can information be released without consent. Please note that the only individuals with access to our files are professional staff members, support staff and any entity having direct administrative control over services provided.
- To receive appropriate, humane services. The staff will strive to provide the best treatment within our resources. You have a right to be free of physical, verbal, emotional, sexual, and/or financial abuse as well as neglect, humiliation or exploitation as per the Mental Health and Developmental Disabilities Code [405 ILCD 5].
- To receive any intrusive procedures such as injections, ect, in a safe manner, with consideration to the physical, developmental and abuse history of the persons served.
- To choose whether or not to participate in research projects.
- To receive concurrent services, i.e. to see the doctor and/or a counselor, case manager, ect.
- To participate in developing your treatment plan and to be informed of the composition of your Treatment Team.
- To have you bill and specific charges explained to you and to question any charges you believe may be in error.
- To contact the Network Manager for the Department of Human Services.
- To know what medication is prescribed for you, why it is prescribed and possible side effects it may cause.
- To review your record with the assistance of program staff in accordance with agency policy.

- To the right to give or withhold informed consent regarding treatment and regarding confidential information.
- To request alternative channels of communication.
- To refuse treatment or any specific treatment procedure and be informed of the consequences resulting from such refusal in a timely manner to allow you to make an informed decision regarding your treatment.
- To be free from retaliation for expression of concerns, problems, grievances, ect.
- To terminate services- our services are voluntary and require your cooperation.
- You will not be denied, suspended or terminated from services, or have services reduced for exercising any of the above named rights.
- To be free from seclusion and/or restraint.

CLIENT RESPONSIBILITIES:

As a service recipient you have the following responsibilities:

- To be an active participant in the treatment process and development of a treatment plan. It is expected that you will work on tasks aimed toward helping you attain your stated goals away from, as well as during, treatment sessions.
- To honestly discuss any changes you want to make in your treatment plan, usage of medication, or desire to continue in treatment sessions.
- To be on time for scheduled sessions. If you must cancel we ask that you notify us 24 hours in advance of your appointment. It is our policy to bill for failed appointments.
- To pay your bill in full for services provided, or make arrangements with the business office to make payments. We will do what we can to accommodate you, but you must ask.
- To protect the confidentiality of other members of any group or program in which you participate.
- To refrain from any tobacco use on any MCHD property, including personal vehicles on MCHD property.
- To neither bring or be in possession of any illicit drugs and/or weapons of any type onto MCHD property.
- To avoid behaviors that can result in the termination from or restrictions of services, including:
    - Inappropriate gestures or comments of a sexual nature toward other persons served or staff.
    - To be in the possession of dangerous or hazardous materiel or weapons.
    - Possession of illegal or illicit drugs on MCHD property, exception will be made for those voluntarily relinquishing custody to a clinician.
    - Any remarks or speech that intentionally reduces the self esteem of staff or persons served that includes, but is not limited to, remarks of race, religion, national origin, gender/transgender, sexual orientation, and physical/mental handicaps.
    - Intentional misuse of prescribed medications.
    - To physically threaten or assault other persons served or staff.

GRIEVANCE PROCEDURE:

If you feel a decision made regarding your treatment or the treatment of the individual you are guardian of was unfair, or there has been an infringement of your rights, you have the right to appeal.

The appeal process is as follows:

You must indicate to your counselor/therapist/case manager in writing that you have a grievance and the nature of the grievance. If your grievance is with your counselor/therapist/case manager you may present your written grievance to their supervisor. He/She will then contact you to set a meeting time with you to discuss your concerns within 72 hours of your request.

If you are not satisfied with the results of this conference you may appeal in writing to the following people:

1. Director of Mental Health
2. Administrator of the Health Department

The process of appeal must start with the first step and you may go through each step until you are satisfied. At each step you will be provided with a written response to your grievance with in ten (10) working days of your meeting.

All staff member dealing directly with clients will advise all individuals of their rights in accordance with documents cited above.

If you need assistance with writing your grievance, please let us know and an impartial staff member will be assigned to assist you.

If you have a grievance which you believe was not satisfactorily resolved after completion of the agency grievance procedure, you may contact:

Illinois Department of Human Services, Office of Alcoholism and Substance Abuse
Division of Licensing and Monitoring
222 South College, Second floor
Springfield, Illinois 62704
(217) 782-0685

Illinois Department of Human Services, Office of Mental Health and Developmental Disabilities
401 S. Spring
Springfield, Illinois 62701
(217) 782-9375 1-800-843-6154

Guardianship and Advocacy Commission (GAC)
Metro East Regional Office
Pine Cottage
4500 College Ave
Alton, IL 62002-5099
(618) 474-5503 Fax (618) 474-5517

Equip for Equality
427 E. Monroe Street
Springfield, Illinois 62701
(217) 544-0464

Illinois Department of Human Services, Office of Children and Family Services
1010 N. High
Carlinville, Illinois 62626
(217) 854-2566

Land of Lincoln Legal Assistance
413 East Broadway
Alton, IL 62002
(618)462-0029
800-642-5570

Department of Corrections
1301 Concordia Court
Springfield, Illinois 62794-9277
(217) 522-2666

Network Manager for the Department of Human Services
901 South Wind Road
Springfield, IL 62703

NAMI
Gateway Regional Medical Center
2100 Madison Ave. 4th floor
Granite City, IL 62040
618-798-9788

Alcoholics Anonymous
Southern Illinois District 18
800-307-6600

Our services are funded in part by the Department of Human Services: the Office of Mental Health and Developmental Disability, and the Office of alcoholism and Substance Abuse. The Federal Government also provides funding dollars.

Rev. 5-07, 6-07, 8-10
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NOTICE OF PRIVACY PRACTICES

Effective: April 14, 2003

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

This notice will tell you how we may use and disclose (give to others) health information about you. All such uses and disclosures are governed by the Confidentiality Act of Alcohol and Drug Abuse Patient Records regulations (42 CFR 2(1987), of the Alcohol, Drug Abuse and Mental Health Administration, of the Public Health Service, of the United States Department of Health and Human Services and Mental Health, of the Developmental Disabilities Confidentiality Act (740 ILCS 110) and the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. & 1320dd2). We use and disclose medical information about you for a number of different purposes as described in the following:

- We may use medical information about you to provide treatment, coordinate or manage your health care and related services. We may disclose medical information about you to other health care providers who become involved in your care. We may consult with other health care providers concerning you, and as part of the consultation share your medical information with them. For example, if you need to receive services from a physician with a particular specialty, we will disclose medical information to them or their office so they have the information they need to provide services for you.
- We may use and disclose medical information about you so we can be paid for the services we provide to you. We do bill you, and unless you choose otherwise, your insurance company, Medicare, Medicaid or third party payor. For example, we may need to give your insurance company information about the health care services we provide to you so your insurance company can determine eligibility for payment and will pay us for those services or reimburse you for amounts you have paid. If you choose not to have your insurance company billed you will be responsible for the full bill. If a grant funding source is paying for the services you receive, we may be required to give them information about you and your treatment.
- We may use and disclose medical information about you for our own health care operations. These are necessary for us to operate MCHD and to maintain quality health care for our patients. For example, we may use medical information about you to review the services we provide and the performance of our employees in caring for you. We may disclose medical information about you to train our staff and students working at MCHD. We also may use the information to study ways to more efficiently manage our organization.

Unless you tell us otherwise in writing, we may contact you by either telephone or by mail at either your home or your workplace. We may leave messages for you on the answering machine or voice mail. We may use and disclose medical information about you to contact you to remind you of an appointment you have with us. We may use and disclose medical information about you to contact you about treatment alternatives or health related benefits or services that may be of interest to you. If you want to request that we communicate to you in a certain way or at a certain location, you have the right to request how we communicate medical information about you to you. For example, you can ask that we only contact you by mail or at work. We will not require you to tell us why you are asking for the confidential communication.

If you want to request alternative channels of communication, you must do so in person to the Intake staff or the Privacy Officer You must state how or where you can be contacted. We will accommodate reasonable requests. However, we may require information from you concerning how payment will be handled.

We may disclose to a family member, other relative, a close personal friend, or any other person identified by you, medical information about you that is directly relevant to that person's involvement with your care or payment related to your care. We also may use or disclose medical information about you to notify, or assist in notifying, those persons of your location, general condition, or death. If there is someone, such as a family member, other relative or close personal friend, you do **not** want us to disclose medical information about you, please notify the Privacy Contact person or the Privacy Officer.

Subject to certain requirements, we may give out health information without your authorization for:

- Disaster relief purposes [45 CFR~164.510 (b)(4)]
- As required by law [45 CFR~164.512 (a)]
- Public Health activities [45CFR~164.512(b)]
- Victims of abuse, neglect or domestic violence [45 CFR~164.512(c)]
- Health oversight activities [45 CFR~164.512(d)]
- Judicial and administrative proceedings [45 CFR~164.512(e)]
- Disclosures for law enforcement purposes [45 CFR~164.512(f)]
    - As required by law.
    - To identify or locate a suspect, fugitive, material witness or missing person.
    - About an actual or suspected victim of a crime and that person agrees to the disclosure. If we are unable to obtain that person's agreement, in limited circumstances, the information may still be disclosed.
    - To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct.
    - About crimes that occur at our facility
    - To report a crime in emergency circumstances.
- Coroners and Medical Examiners [45 CFR~164.512(g)(1)]
- Funeral Directors [45 CFR~164.512(g)(2)]
- Research [45 CFR~164.512(i)]

- To avert serious threat to health or safety (yours or others) [45 CFR~164.512(j)]
- Military activities [45 CFR~164.512(k)(1)]
- National security and intelligence [45 CFR~164.512(k)(2)]
- Protective services to the President [45 CFR~164.512(k)(3)]
- Inmates; persons in custody [45 CFR~164.512(k)(5)
- Workers Compensation [45 CFR~164.512(l)]

Other Uses and Disclosures.

Other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by notifying the Privacy Officer in writing of your desire to revoke it. However, if you revoke such an authorization, it will not have any affect of actions taken by us in reliance of it.

Your Rights With Respect to Medical Information About You.

You have the following rights with respect to medical information that we maintain about you.

You have the right to request that we restrict the uses or disclosures of medical information about you to carry out treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to any person identified by you. For example, you could ask that we **not** disclose medical information about you to a family member. To request a restriction, you may do so at this time or at any other later time. If you request a restriction, you should do so to the Privacy Officer or the Privacy Contact person. And tell us: (a) what information you want to limit; (b) weather you want to limit use or disclosure or both; and, (c) to whom you want the limits to apply (for example, disclosures to your spouse).

We are not required to agree to any requested restriction. If we do agree to the restriction, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, either you or we can later terminate the restriction.

With a few very limited exceptions you have the right to inspect and obtain a copy of medical information about you.

You must submit your request in writing to the Privacy Officer. Your request should state specifically what medical information you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying, and if you ask that it be mailed to you, the cost of mailing.

We will act on your request within thirty (30) calendar days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying.

We may deny your request to inspect and copy medical information if the medical information involved is:

- Psychotherapy notes created by a clinical psychologist or clinical social worker;
- Information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding;

If we deny your request, we will inform you of the basis for the denial, how you may have our denial reviewed, and how you may complain. If you request a review of our denial, it will be conducted by a licensed health care professional designated by us who was not directly involved in the denial. We will comply with the outcome of that review.

You have the right to ask us to amend medical information about you. You have this right for as long as the medical information is maintained by us.

To request an amendment, you must submit your request in writing to the Privacy Officer. Your request must state the amendment desired and provide a reason in support of that amendment.

We will act on your request within sixty (60) calendar days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying. If we grant the request, in whole or in part, we will seek your identification of and agreement to share the amendment with relevant other persons. We also will make the appropriate amendment to the medical information by appending or otherwise providing a link to the amendment.

We may deny your request to amend medical information about you. We may deny your request if it is not in writing and does not provide a reason in support of the amendment. In addition, we may deny your request to amend medical information if we determine that the information:

- Was not created by us, unless the person or entity that created the information is no longer available to act on the requested amendment;
- Is not part of the medical information maintained by us;
- Would not be available for you to inspect or copy; or
- Is accurate and complete.

If we deny your request, we will inform you of the basis for the denial. You will have the right to submit a statement of disagreeing wit hour denial. Your statement may not exceed four (4) pages. We may prepare a rebuttal to that statement. Your request for amendment, our denial of the request, your statement of disagreement, if any, and our rebuttal, if any, will then be appended to the medical information involved or otherwise linked to it. All of that will then be included with any subsequent disclosure of the information, or, at our election, we may include a summary of that information.

If you do not submit a statement of disagreement, you may ask that we include your request for amendment and our denial with any future disclosures of the information. We will include your request for amendment and our denial with any future disclosures of the information. We will include your request for amendment and our denial (or a summary of that information) with any subsequent disclosure of the medical information involved. You also have the right to complain about our denial of your request.

You have the right to receive an accounting of disclosures of medical information about you.

The accounting may be for up to three (3) years prior to the date on which you request the accounting but not before April 14, 2003.

Certain types of disclosures are not included in such an accounting:

- Disclosures to carry out treatment payment and health care operations;
- Disclosures of your medical information made to you;
- Disclosures that are incidental to another use or disclosure;
- Disclosures that are authorized by you;
- Disclosures for disaster relief purposes;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials having custody of you;
- Disclosures that are part of a limited data set for purposes of research, public health, or health care operations (a limited data set is where things that would directly identify you have been removed);
- Disclosures made prior to April 14, 2003.

Under certain circumstances your right to an accounting of disclosures may be suspended for disclosures to a health oversight agency or law enforcement official. Should you request an accounting during a period of time when your right is suspended, the accounting would not be included in the disclosure or disclosures to a law enforcement official or to a health oversight committee.

To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period for the disclosures. It may not be longer than six (6) years from the date we received your request and may not include dates before April 14, 2003. Usually, we will act on your request within sixty (60) calendar days after we receive your request. Within that time, we will either provide the accounting disclosures to you or give you a written statement of when we will provide the accounting and why the delay is necessary. There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost involved and give you and opportunity to withdraw or modify your request to avoid or reduce the fee.

The current Notice of Privacy Practices will be posted in the waiting areas of the MCHD premises. You have the right to obtain a paper copy or an e-mail copy of our Notice of Privacy Practices. You may request a copy of our Notice of Privacy Practices at any time. 'To obtain a paper copy of this notice, contact the Privacy Officer at MCHD (217)532-2001. You may obtain a copy of the current Notice of Privacy Practices over the Internet at our Website, www.montgomeryco.com/health/.

Our Duties

We are required by law to maintain the privacy of medical information about you and to provide individuals with notice of our legal duties and privacy practices with respect to medical information. MCHD does not use any of your information for fundraising purposes. We are required to abide by the terms of our Notice of Privacy Practices in effect at the time. We reserve the right to change this Notice of Privacy Practices. We reserve the right to make the new notice's provisions effective for all medical information that we maintain, including that created or received by us prior to the effective date of the new notice.

The effective date of the notice will be stated on the first page of the notice. You may complain to us and to the United States Secretary of Health and Human Services if you believe your rights have been violated by us. To file a complaint with us, contact the Privacy Officer at 11191 IL Rt. 185, Hillsboro, IL 62049. All complaints should be submitted in writing. To file a complaint with the United States Secretary of Health and Human Services, send your complaint to him or her in care of: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington D.C., 20201.

You will not be retaliated against for filing a complaint.

If you have any questions or want more information concerning this Notice of Privacy Practices, please contact the Privacy Officer at the Montgomery County Health Dept at (217)532-2001.

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