Staff Printed Name: _____
Staff Initials: _____

Behavioral Services Center
DUI Risk Education Services

8707 Skokie Boulevard - Suite #207, Skokie, IL, 60077
Phone: (847) 673 - 8577 | Fax: (847) 568 - 0411

Behavioral Services Center: Patient Demographic Form

Personal Information

Last Name:_____First Name:_____Middle Initial: _____

Is this your legal name? Please indicate: ☐ Yes ☐ No

If not, please provide your legal name: _____

Former name: _____

Please select the applicable option: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Age: _____

Indicate current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Social Security Number: _____

Birth Date: _____/_____/_____Gender: ☐ M ☐ F ☐ Non-Binary

Parent/Guardian/ or Significant Other Info: First/Last Name: _____

Relationship to Client: ☐ Parent ☐ Guardian ☐ Significant Other (Specify): _____

Race/Ethnic Origin: _____ Religion: _____

First Language: _____ Second Language: _____

Interpreter Services: ☐ None Required ☐ American Sign Language ☐TDD/TYY

☐ Spoken Language ☐ Other: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

P.O Box: _____

Phone Number: (____)_____-_____ Cell Number: (____)_____-_____

Email Address: _____

Referred By: _____ Preferred Method of Communication: _____

Behavioral Services Center:
Authorization to Disclose/Obtain Information

I _____ (print name) authorize Behavioral Services Center to disclose and obtain the following information:

- Evaluations
- Assessments
- Treatment Plans
- Progress Notes
- Discharge Summaries
- Billing Financial Records
- Other (Specify Here): _____

For the purposes of:

- Personal Use
- Continuity of Care
- Referral/Transfer
- Billing
- Case Management
- Other (Specify Here): _____

Information may be disclosed/obtained via mail, in-person, phone, email, or fax.

Disclose to: First/Last Name: _____

Address: _____ City/State/Zip: _____

Phone/Fax/Email: _____

Obtain From: First/Last Name: _____

Address: _____ City/State/Zip: _____

Phone/Fax/Email: _____

This Authorization is valid until: _____/_____/_____

It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as mental health and substance abuse. I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations. I understand that I may revoke this authorization; however, the revocation must be in writing to the Behavioral Services Center. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communication until it is received by the Behavioral Services Center. Refusal to sign this form will result in no information to be disclosed or obtained. Your refusal to sign an Authorization to Disclose/Obtain Information will not prevent treatment.

Signature Date

US Citizen: □ Yes □ No □ Other: _____

Military Status: □ Veteran □ Active □ Reserve □ None

Driver's License Number: _____ Medicaid # (if applicable): _____

Employee Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Other:_____

Occupation: _____ Annual Household Income: _____

Living Arrangement: □ Lives Alone □ Family Household □ Independent Living
□ State Operated Facility □ Foster Care □ Homeless
□ Lives with parent(s), or guardian(s) □ Jail or Correctional Facility
□ Residential/INstitutional Setting □ Community Integrated Living
□ Other: _____

Highest Education: □ Never attended □ Pre-K/Kindergarten □ Grade 1-3
□ Grade 4-5 □ Grade 6-8 □ Grade 9-12 □ H.S Diploma/GED
□ Some College □ Associate's Degree □ Bachelor's Degree
□ Trade/Technical Training □ Professional Certificate
□ Master's/Doctoral Degree

Established Supports _____

Physician: Agency: _____Contact Name: _____
Phone: _____ Email: _____

School/Daycare: Agency: _____Contact Name: _____
Phone: _____ Email: _____

Counselor/Therapist: Agency: _____Contact Name: _____
Phone: _____ Email: _____

Child Welfare Worker: Agency: _____Contact Name: _____
Phone: _____ Email: _____

ISC/PAS Agent: Agency: _____Contact Name: _____
Phone: _____ Email: _____

Probation Officer: Agency: _____Contact Name: _____
Phone: _____ Email: _____

Other:_____: Agency: _____Contact Name: _____

Phone: _____ Email: _____

Other:_____: Agency: _____Contact Name: _____

Phone: _____ Email: _____

Other:_____: Agency: _____Contact Name: _____

Phone: _____ Email: _____

Insurance Information

Please indicate primary insurance: _____

Group #: _____ Policy #: _____

Co-Payment: _____ Birth Date: _____/_____/_____

Subscriber's Name: _____ Subscriber's S.S #: _____

Patient's relationship to the subscriber:_____

Name of Secondary insurance (if applicable): _____

Subscriber's Name: _____ Subscriber's S.S #: _____

Birth Date: _____/_____/_____ Group #: _____

Policy #: _____ Co-Payment: _____

Person responsible for bill: _____ Birth Date: _____/_____/_____

Address (if different): _____

Phone Number: (____)_____-_____ Cell Number: (____)_____-_____

In Case of Emergency

Name of local friend or relative (not living at same address): _____

Relationship to patient: _____

Phone Number: (____)_____-_____ Cell Number: (____)_____-_____

Other Contact Information: _____

I **authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance and believe that the above information is true to the best of my knowledge.**

Signature Date

Behavioral Services Center: Client's Rights

The Behavioral Services Center (BSC) is determined to provide the best and the most appropriate care to its clients. The BSC is obliged to protect its clients' rights and treat every Client with respect. The BSC guarantees to adhere to the following policies:

- BSC does not discriminate against its clients on the basis of race, religion, ethnicity, disability, sexual orientation, or HIV status.
- BSC will not deny mental health or substance abuse services because of age, sex, race, sexual orientation, HIV status, religious belief, ethnic origin, marital status, physical or mental disability or criminal record unrelated to present dangerousness.
- The client has a right to be free from abuse, neglect, retaliation, humiliation and financial and other exploitation.
- The client has a right to confidentiality and privacy within the limits of the law (The Illinois MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT).
- The client has a right to be provided services in the least restrictive setting.
- The client has a right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
- The client has the right to contact the Illinois Guardianship and Advocacy Commission and Equip for Equality, Inc. BSC will offer assistance to a client in contacting these groups, giving each client the address and telephone number of the Illinois Guardianship and Advocacy Commission and Equip for Equality.
- The client has the right to contact HFS or its designee of the clients healthcare benefit and the process for reviewing grievances.

BSC ensures that none of its facilities used for the face-to-face interviews are locked and its clients are never placed in seclusion or in an environment from which they cannot voluntarily exit.

BSC understands and guarantees that all information that it receives about its clients is strictly confidential in accordance with the Illinois MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT. In particular, if the BSC finds out information about the Client's HIV/AIDS status, it will keep this information strictly confidential. The BSC will keep the results of the Client's anonymous drug or HIV testing strictly confidential. BSC will keep mental health and substance abuse information confidential. BSC guarantees that *all* clients regardless of their disability have access to its services in the facility. BSC will provide special accommodations to clients with disability on an individual

basis as required by the American with Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS5].

Every client has the right to sign or withhold consent to release information about services received on The Release of Information Consent Form. Clients may authorize BSC to share treatment information by signing a consent form. BSC will provide access or referral to legal entities for appropriate representation, self-help support services and advocacy support services.

If a client disagrees with BSC's policies and procedures, they can appeal in writing to the management and the board of directors. BSC will provide a written response within 10 business days to the submitted appeal. Every appeal will be considered on a case-by-case basis. Clients cannot file an appeal regarding the same policy of the BSC more than three times. The client has the right to request communication about their own health information by alternative means or to alternative locations. Clients must make this request in writing. The request must specify the alternative means or location, and provide satisfactory explanation in regards to payments handled under the alternative means or location you request. The client has the right to refuse treatment and refuse treatment recommendations including medication but BSC may refuse to continue providing services and provide referrals to other service providers. BSC will provide information to the client in sufficient time to facilitate decision making. If the client is potentially harmful to self or someone else or is unable to take care of self, this section may not apply and we will assist in stabilizing the client before referring elsewhere.
Clients have the right to review or receive copies of his/her health information. The Client must make a request in writing to obtain access to their health information. If the client requests copies, the BSC will charge a reasonable cost-based fee. The client has the right to be involved in their own treatment plan and to know the risks and benefits of treatment and other options. Informed consent or refusal for assessment and treatment will be obtained in writing by BSC. The client also has a right to informed consent or refusal related to the service delivery, concurrent services, composition of the service delivery team, and involvement in research projects as applicable.

The client has the right to receive a list of instances in which BSC or BSC's business associates disclosed the client's information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years. If Client requests this information more than once during any 6 month period he/she will be charged a cost-based fee. The client has the right to request that BSC place additional restrictions on the use or disclosure of his/her health information. The BSC is not required to agree to these additional restrictions but if the BSC does, it will abide by our agreement (except in an emergency). The client has the right to request that BSC amends his/her health information. Client's request must be in writing and

explain why the information should be amended. The BSC may deny a Client's request under certain circumstances.

If a client is 12 years or older, they have the right to read and/or copy the records. Clients must request this in writing. There is a fee for photocopying. If Client is under the age of 18, the BSC must provide someone to help explain Client's records. Clients may refuse this help. Client's parent(s) or guardian(s) also have the right to read and copy of the Client's record; however, Client may decline to allow them to review your record. If Client gives other people permission to read or copy your record, it must be in writing. If the client is 12-18 years old, the client and therapist may object to information being given to Client's parent or guardian. All clients' records are kept strictly confidential. All clients' records are kept in a secure environment, secure file lock, and can be accessed only by authorized BSC personnel. All clients of the BSC have the right to refuse the services. In this circumstance, BSC staff must inform the client of the consequences resulting from such refusal and make sure that the client understands them.

This Notice of Privacy Practices explains how the Behavioral Services Center (BSC), its clinical staff may use and provide your Protected Health Information (called PHI) to others for treatment, payment, and health care "operations" as described below, and for other purposes allowed or required by law.

1. OUR RESPONSIBILITIES: The BSC takes the privacy of your and your child's health information seriously. We are required by law to keep your health information private and provide you with this Notice of Privacy Practices. We will act according to the terms of this Notice. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for all Protected Health Information that we keep.

2. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)? Protected Health Information (PHI) is information about a patient's age, race, sex, and other personal health information that may identify the patient. The information relates to the patient's physical or mental health in the past, present, or future, and to the care, treatment, and services needed by a patient because of his or her health.

3. WHAT DOES "HEALTH CARE OPERATIONS" INCLUDE? "Health care operations" includes activities such as discussions between clinical staff; evaluating and improving quality; making travel arrangements to and from the BSC; arranging temporary housing; reviewing the skills, competence, and performance of health care staff; training future health care staff; dealing with insurance companies; carrying out medical reviews and auditing; collecting and studying

information that could be used in legal cases; and managing business functions.

4. HOW IS MEDICAL INFORMATION USED? The BSC uses medical records to record health information, to plan care and treatment, and to carry out routine health care functions. For example, your insurance company may need us to give them procedure and diagnosis information to bill for patient treatment we provide. Other health care providers or health plans reviewing your records must follow the same privacy laws and rules that the BSC is required to follow. Patient records also greatly help our researchers find the best possible treatment for diseases and medical conditions. All BSC
researchers must follow the same rules and laws that other health care providers have to follow to keep patient information private. Details that may identify patients will not be disclosed for research purposes to anyone outside of the BSC without written permission from the patient or the patient's parent or legal guardian.

5. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

● Medical information may be used to show that a patient needs certain care, treatment, and services (such as lab tests, prescriptions, treatment plans, and research study requirements).

● We will use medical information to plan treatment.

● We may disclose Protected Health Information to another provider for treatment (such as, referring doctors, specialists, and providers at the Behavioral Services Center).

● We may send claims to your insurance company containing medical information. We might also contact their utilization review department to receive precertification (approval for treatment in advance).

● We may use the emergency contact information you gave us to contact you if the address we have on record is no longer correct.

● We may contact you to remind you of the patient's appointment by calling you or mailing a postcard.

● We may contact you to discuss other possible treatments or benefits related to health that might interest you.

● We may use information to schedule travel to and from Behavioral Services Center.

● The patient's name, home address, location in Behavioral Services Center housing, and arrival date may be given to ALSAC, a charitable organization with the sole purpose of raising funds for Behavioral Services Center. Before any more information is given to ALSAC, you will be asked to sign another consent document known as an Authorization Form

6. WHY DO I HAVE TO SIGN A CONSENT FORM? When you sign the Consent for Release of Information, you are giving the BSC permission to use and disclose (provide to others) Protected Health Information for treatment, payment, and health care operations, as described above. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records, and other privileged categories of information, all of which require a separate permission. You will need to sign a separate consent form to have Protected Health Information given out for any reason other than treatment, payment, or health care operations or as required or permitted by law.

7. WHAT ARE PSYCHOTHERAPY NOTES? Psychotherapy notes are notes recorded (in any form) by a mental health professional for the purpose of studying a conversation that took place during a private counseling session. This session can be with a single person, a group, or a family. Conversation notes from a counseling session are separated from the rest of the patient's medical record. Psychotherapy notes do not include: notes about which medicines you are taking or how those medicines affect you; the start and stop times of counseling sessions; the types of treatment you are given; how often treatments are given; the results of clinical tests; and any summary of the following items: diagnosis, functional state, the treatment plan, symptoms, expected outcome, and progress to date.

8. WHAT IS PSYCHOSOCIAL INFORMATION? Psychosocial information is information given to your social worker about your family's social history and counseling services you have received.

9. WHY DO I HAVE TO SIGN A SEPARATE PERMISSION FORM? To provide patient Protected Health Information to other people for any reason other than treatment, payment, and health care operations (described above) or as required or permitted by law, we must have a permission form known as an Authorization Form signed by the patient or the patient's parent or legal guardian. This form clearly explains how they wish the information to be used and disclosed. The following are some examples of information that require separate permission before we can release it:

● Psychotherapy notes

● Information and photographs shared with ALSAC for its fundraising and public relations activities

● Information used in scientific and educational publications, presentations, and materials related to the work at BSC

● Information shared with other clinical and scientific cooperative groups that Behavioral Services Center works with in carrying out its mission to advance cures, and means of

prevention, for pediatric catastrophic diseases through research and treatment.

10. CAN I CHANGE MY MIND AND WITHDRAW PERMISSION FOR BSC TO DISCLOSE PHI? You may change your mind and withdraw (revoke) permission, but we cannot take back information that has been released up to that point. Permission cannot be withdrawn if (1) the information is needed to maintain the integrity of the research study, or (2) if the permission was originally given to obtain insurance coverage. All requests to withdraw permission for uses and disclosures of PHI should be made in writing. The request should be submitted to Patient Registration, which will then forward this information to the Privacy Officer and the Director of Health Information Management.

11. WHEN IS MY CONSENT *NOT* REQUIRED? The law requires that some information may be disclosed without your permission during the following times:

- In an emergency
- When communication or language is very limited
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected child abuse or neglect
- To report Elder abuse
- To report information under the Firearm Owners Identification Act (FOID)
- To certain government agencies who monitor activity
- In connection with court or government cases
- For law enforcement purposes
- To coroners and funeral directors and for organ donation
- If health or safety is seriously threatened

12. GRIEVANCE PROCEDURE: You have the right to file a grievance for any concerns you have related to BSC including a violation of the above rights, concerns about treatment, or other concerns:

CLIENT GRIEVANCE POLICY & PROCEDURE:

It is the policy of Behavioral Services Center (BSC) to have a prompt and responsive way for you to submit a concern or complaint, free from intimidation or retaliation with the right not to be denied, suspended or terminated from services or have services reduced for exercising any

rights. If you have a concern or complaint about services provided by us, BSC will make reasonable efforts to come to a solution that is agreeable to all parties involved. Each client has the right to designate a representative or advocate to assist them with all of the stages of the grievance process and/or request the agency to assist them in filing a grievance if they so desire.

STEP ONE INFORMAL STAGE Talk first to your primary provider about the matter. Allow a reasonable response time for the two of you to talk out the situation. Present your viewpoint clearly. Be calm and reasonable in your presentation to your primary provider. It may help if you write it out. If you do not agree with the outcome or you feel your concern has not been addressed adequately, you may follow the procedures for STEP TWO below.

STEP TWO FORMAL STAGE If your grievance is not resolved, you may request a meeting with the Clinical Services Director, Dr. Eugene Isyanov, by filling out the attached Formal Grievance Form. Your primary provider or the front desk can provide a form for you and you can turn it in to any BSC employee. Then an appointment will be arranged with Dr. Isyanov.

Review the situation with the Dr. Isyanov. Include the solution you wish to see. You will be asked if you covered the information with your primary provider and turned in the Formal Client Grievance Form before you requested this appointment. If you did not, you will be referred back to the appropriate person, unless you can clearly identify why you should not talk to your primary provide about the matter. The Clinical Services Director, Dr. Isyanov, will make every attempt to resolve the matter. It is possible that Dr. Isyanov may take some time to weigh all viewpoints before making a decision, so don't expect an immediate response. You can expect a response within 2 weeks of meeting Dr. Isyanov, his decision is final. If your primary provider is Dr. Isyanov, another administrator will be assigned to meet with you.

13. RIGHT TO ADEQUATE AND HUMANE CARE: You will be assigned a therapist (e.g. social worker or psychiatrist) who will work with you on an individual Treatment Plan. You will be treated with dignity and respect. If you do not feel you are receiving adequate or humane care, you should report this to your therapist. You may also file a grievance as indicated in the grievance procedure above.

14. RIGHT TO BE FREE FROM ABUSE AND NEGLECT: It is your right to obtain treatment that is free from abuse and/or neglect.

15. RIGHT TO INFORMED CONSENT: You have the right to be involved in your treatment plan and to know the risks and benefits of treatment and other options.

16. RIGHT TO REFUSE TREATMENT: You have the right to refuse treatment, including

medication but we may not be able to continue to serve you. If you are potentially harmful to yourself or someone else, this section may not apply.

17. RIGHTS TO CONFIDENTIALITY: All information gathered while you are receiving services from us will be kept private unless:

1. You sign a written release indicating specific information to be released to another person or agency.

2. We receive a Court order to release information.

3. You have a Medical Emergency.

4. You might harm yourself or others.

5. You are unable to take care of yourself.

6. I consent to the use or disclosure of my protected health information by Clinicians for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Clinician.

7. Other exceptions as prescribed by law.

18. RIGHT TO ACCESS RECORDS: If you are 12 years or older, you have the right to read and or copy your records. You must request this in writing. There is a fee for photocopying. If you are under the age of 18, we must provide someone to help explain your records. You may refuse this help. Your parent(s) or guardian(s) also have the right to read and copy your record.

You have the right to ask that information in your file be changed, but we do not have to change the record. If we do not change the information, you may: 1. Put your own information in the file. Any time the information is released, your information will also be released. 2. Go to Court to attempt to have us change your information.

If we suspect a child with whom you are involved is abused or neglected, or we learn of child abuse or neglect we are mandated to report it to DCFS.

If you are 12-18, you and your therapist may object to information being given to your parent or guardian. Your parents or guardian in such a situation may petition the Court to review your

record.

We will only release specific information needed to meet the request or situation. These situations are:

1. When your therapist is mandated by the Federal, State Authorities to report if you have committed a crime on our property, or if threats are made against our organization, its staff or others.

2. If this clinic is audited by Federal, State or Local authorities, e.g. Public Health, Medicare, Public Aid, the Joint Commission of Accreditation Organization.

3. Your therapist may share information with his/her supervisor and co-workers when it is needed to help with treatment.

If your rights are restricted in any way by us, we must justify the restriction of any documentation in your file. You or your parent(s) or guardian or the above identified agencies will be notified of the restriction. You may not be denied, suspended, or terminated from service or have services reduced for exercising any of your rights. The rights included herein apply to you as well as all patients who receive services in our clinic. We request that you respect the rights and confidentiality of all patients who receive services. Your rights are protected in accordance with the Illinois Mental Health and Disabilities Code and the Illinois Mental

Health, HIPAA and Disabilities Confidentiality [Confidentiality Act [740 ILCS 110] and HIPAA (45 CFR 160 and 164)]. This is a summary of your rights. Please read them and/or have them read and explained to you. If you require additional help such as a translator, we can provide that service for you. After you read and understand your Rights, please sign this document indicating you have read and understand it and have been given a copy of the document.

I **, I agree and consent to that I have read and understood the Client's Rights and been provided a copy of this Client's Rights Document.**

Signature Date

Behavioral Services Center:

Informed Consent for Telemedicine Services

Introduction

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video
- Output data from medical devices and sound video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Medical Information & Records

All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, no telecommunications are recorded and stored.

Confidentiality

Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Illinois law apply to information disclosed during this telemedicine consultation.

Rights

You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

Risks, Consequences, & Benefits

You have been advised of all potential risks, consequences and benefits of telemedicine. Your health care practitioner has provided the information above and you have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions, if present, have been answered and you understand the written information provided above.

I **, I agree to participate in telemedicine consultations for procedure(s) provided by the Behavioral Services Center.**

Signature Date

Behavioral Services Center: Consent For Mental Health And Substance Abuse Evaluation And Treatment

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I, (print name) _____ hereby consent to receive Mental Health and/or receive Mental Health and/or Substance Abuse Evaluation and/or Treatment from Behavioral Services Center, P.C.:

Behavioral Services Center.
P.C.

8707 Skokie Blvd., Suite 207 Skokie, IL 60077 188
Industrial Drive, Suite 100 Elmhurst IL. 60126 25980
Diamond Lake Road, Suite 111 Mundelein, IL. 60060 161
North Clark Street, Suite 4700 Chicago IL, 60601 310 South
Greenleaf Street, Suite 205, Park City, IL, 60031

I consent to the use or disclosure of my protected health information by Behavioral Health Services for the purpose of obtaining payment for my health care bills.

By signing this Client Information and Consent Form as the Client or Guardian/Parent of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form, in the Client Rights document, and group rules documents (when applicable) that have been provided to me. I acknowledge that I have been provided with these documents and have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive Mental Health and/or Substance Abuse Evaluation and/or Treatment by clinicians at Behavioral Services Center.

I understand I have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. I understand I have the right to ask questions about any aspects of therapy.

I **, I am consenting to Behavioral Services Center providing me with Mental Health and/or Substance Abuse Evaluation and/or Treatment. I have been provided the Client Rights Document and the Group Rules (when applicable to clients receiving group treatment) and agree to their terms.**

Signature Date

Behavioral Services Center: Criteria For Disqualification

1. If a client arrives more than 15 minutes late to the group session or leaves the group session before the end of the group activities (if applicable), this client will be disqualified from the designated service program.
2. If a client fails to sign into the Attendance Sheet before and/or after class, it will be considered as a client's failure to attend this group session and might lead to the disqualification from the designated service program.
3. If a client arrives more than 15 minutes late to the scheduled group after the break, this client will NOT be allowed to continue participating in this group and it will be considered that this client missed the entire group session, which might lead to the disqualification from the designated service program.
4. If a client refuses to participate in any group-related activity, including a participation in the discussion part.
5. Clients are allowed to have 5 minutes to use the restroom during the group, outside break. If more than 5 minutes will be missed during the group, outside break time, it might be considered that a client skipped class and the disqualification from the designated service program might be considered by the group facilitator.
6. Refusal to test BAL.
7. Use of Drugs/Alcohol before or during groups.
8. Use of electronic equipment (phones, pagers, etc.) during class.
9. Disrespectful behaviors in class towards clients and/or group facilitators.
10. Absence from 3 program groups.

I _____ **, I understand and agree to the Criteria for Disqualification above.**

Signature Date

Behavioral Services Center: Office & Financial Policies

Insurance: The patient/guardian (if applicable) is responsible for knowing their insurance benefit coverage. The Behavioral Services Center will file your insurance claim on your behalf. However, we will not become involved in disputes between you and your insurance regarding coverage and/or policy benefit criteria. We will supply any factual information if necessary. You are responsible for the timely payment of your account.

Self Pay: Payment in full is expected at time of service.

Referrals: It is the patient's responsibility to know if referrals are r equired for specialists visits and to inform their Primary Care Physician. On average, allow 4 business days to p process r referrals.

No shows and late cancellations: We require a 24 hour notice for cancellations. The NO SHOW appointment will result in a missed session charge.

I _____ **, I have read, understand, and agree to the above office financial policies. I hereby also authorize release of information necessary for insurance filing and pre-certification.**

Signature Date

Behavioral Services Center:
Information About The DUI/Substance Abuse Evaluation

The purpose of the DUI/Substance Abuse Evaluation is to obtain necessary information to determine the risk for public safety by a DUI Offender AND to recommend an intervention to the DUI Offender and the circuit court of venue or the Office of the Secretary of State.

The purpose of the non-DUI/Substance Abuse Evaluation is to obtain necessary information to determine the presence of clinical symptoms of substance abuse and or/related conditions that have an effect on an individual's quality of life.

The DUI/Substance Abuse Evaluation will consist of a face to face individual interview AND a completion of the self-report and computerized questionnaires. The Evaluation is expected to last for about two hours. The fee for DUI/Substance Abuse Evaluation is $200 plus $10.00 test taking charge.

Evaluation Report will be issued not later than 5 calendar days prior to the Offender's court date, unless otherwise specified by the court rule. A copy of the DUI/Substance Abuse Evaluation Report will be issued to the circuit court of venue or the Secretary of State Office and an Offender.

Behavioral Services Center will notify the circuit court of venue or that Office of the Secretary of State within 5 calendar days when a DUI Offender refuses OR does not sign the DUI/Substance Abuse Evaluation Report after 30 calendar days from the date of the Evaluation.

I read and understand "Information About the DUI/Substance Abuse Evaluation" and agree to receive the DUI/Substance Abuse Evaluation services at Behavioral Services Center.

Name of Client _____

Signature of Client _____

Date _____

Name of Evaluator _____

Signature of Evaluator _____

Date _____

Behavioral Services Center:
Responsibilities Of The Offenders/Substance Abuse Patient In The Facility

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1. All clients must be on time for scheduled services. All services start on time - No exceptions !!!;
2. At the beginning of each session, the sign up sheet will be distributed to clients. Every client must sign up for the session before the beginning of the session; At the end of the session, all clients will be asked to sign up on the Attendance Sheet again (applies to certain groups only);
3. Use the restroom or any other Treatment facilities during the breaks only;
4. A client must be familiar with rules associated with received services(s);
5. Participate in all service-related activities;
6. Sobriety before and after sessions;
7. Drug free before and after sessions;
8. Not to use cellular phones, pagers, etc. during group. All electronic equipment should be turned off;
9. Respected and cordial behaviors toward all clients and counselor;
10. Preserve confidentiality of other clients who participate in the groups and any personal information disclosed during the groups;
11. Preserve a violence free environment.

By signing below, I agree that I understand the above Responsibilities.

Name of Client _____

Signature of Client _____

Date _____

Behavioral Services Center:
Substance Abuse Fee Schedule

Court and Secretary of State
DUI Evaluation/Substance Abuse
/ Mental Health Evaluation. . . . . $ 200

Update DUI/Substance Abuse
Evaluation/Mental Health Evaluation $150

10 Hours DUI Risk Education (Group)
(Including all educational materials) . . . . . $ 159

10 Hours DUI Risk Education (Individual) $500

Moderate Risk - 12 Hours early Intervention
(Fee DOES NOT include continuing care) $275

Significant Risk - 20 Hours Counseling
(Fee DOES NOT include continuing care) $585

DUI High Risk - 75 Hours Counseling
(Fee DOES NOT include continuing care) $1800

Individual Counseling / Psychotherapy
(10 sessions = $1,000) . . . . . $ 120 / Hour

Group Counseling / Education Group
(4 Group sessions = $200) . . . . . $ 120 / Hour

Outpatient Substance Abuse
Treatment Group - One Hour
(12 group sessions = $360) . . . . $50 / Hour

Drug Test/Medical Records Copy Fee . . . . $
25

I ________________________________ accept the above fees of the Behavioral Services Center. I understand that I am responsible to pay the above fees for the received services in full.

Signature Date

Behavioral Services Center:
Verification of Risk Prevention Education

I received Education on HIV, AIDS, TB, and Sexually Transmitted Diseases Prevention and Treatment on the following date:

Date: _____

Name: _____

Signature: _____

Behavioral Services Center:
DUI/DWI/Other Arrest Description

Complete this worksheet as detailed as possible. Describe the arrest, including the situation, circumstances, your feelings, and what exactly happened to you in the space allocated in the question.

1. Describe the Arrest:
    a. Date of Arrest:

    b. What was the situation?

    c. What mood were you in? Were you particularly upset or happy that day?

2. Identify: Please be specific:
    a. How much did you drink?

    b. How long were you drinking?

    c. Where were you?

    d. Who were you with?

3. How were you feeling before you drove that day?

4. Were you aware of your intoxication?

5. Did you consider alternatives to driving?

6. What caused the police officer to notice your intoxication?

7. How was it determined that you were intoxicated?

8. How long did you spend in the Police Office or Jail?

9. How did your family members and/or friend(s) respond to your arrest?

10. What was your blood alcohol concentration (BAC)? If you don't know, why?

11. Describe the court process and the final outcome.
    a. How did you plead?

    b. Did you have an attorney?

    c. What was the cost associated with an attorney?

    d. What was your conviction?

12. Do you agree with your conviction? Why?

Complete the questionnaires pertaining to your Alcohol and Substance Abuse History. Please be as detailed as possible.

1. Describe your previous Alcohol and Substance Abuse History.

    a. Describe all substances that you used in the past and including alcohol ranking them in the order of preference.

    b. In what situations you used each substance the most?

    c. When did you start using each substance?

    d. At what point of your life did you use each substance the most?

    e. When was the most recent use of each substance?

2. Describe your legal history, including the most recent DUI arrest.

3. Describe previous substance abuse evaluation and treatments.

4. Describe your family history of substance abuse. Make sure to include every relative of your family who has a history of substance abuse.

Behavioral Services Center

DUI Risk Education Sign In Sheet

Date of Session	Start Time - End Time	Signature
1.) _____/_____/_____	____:_____ - ____:_____	_____
2.) _____/_____/_____	____:_____ - ____:_____	_____
3.) _____/_____/_____	____:_____ - ____:_____	_____
4.) _____/_____/_____	____:_____ - ____:_____	_____

Behavioral Services Center :
DUI Risk Education Pre/Post Test

Name: _____ Date: _____

Please Indicate if this is your Pre-test or Post-Test

☐ Pre Test
☐ Post Test

Please only check ONE answer:

1. Alcoholism is a:
   - ☐ a. Bad habit that is not an illness
   - ☐ b. Illness that is considered a chronic disease that is influenced by genetics, environmental situation, and an individual's predisposition to alcohol.
   - ☐ c. A curable disease that is just a temporally emotional state.
   - ☐ d. A personal choice because an individual is unwilling to live a normal life
2. Alcohol is a:
   - ☐ a. A CNS Stimulant
   - ☐ b. A drug just like Heroin
   - ☐ c. An anti-anxiety or depressant remedy
   - ☐ d. A CNS Depressant
3. Alcoholics:
   - ☐ a. Drink all the time
   - ☐ b. Are unable to control their drinking habits
   - ☐ c. Are at risk to develop psychological problems
   - ☐ d. Frequently feel guilty about their drinking habits
   - ☐ e. B, C, and D.
4. Which of the following are physiological effects of alcohol when individual drink too much alcohol?
   - ☐ a. Impairs an individual's judgement
   - ☐ b. Impairs and individual's reflexes by slowing their response time down
   - ☐ c. Impairs and individuals vision by blurring their sight
   - ☐ d. All of the above

5. The Implied Consent Law requires drivers to and denies the right to:
   - ☐ a. Illinois law requires you to take a breath, blood, or urine test if you are arrested for DUI.
   - ☐ b. Complete the DUI Risk Education Program
   - ☐ c. To have the right to speak to an attorney before you are tested
   - ☐ d. A and C
6. How does liver rid alcohol from the body?
   - ☐ a. Through liver oxidation
   - ☐ b. Through time associated with liver oxidation
   - ☐ c. Through urination and time
   - ☐ d. Through digestion

7. What is the Blood alcohol concentration (BAC), mean?
   - ☐ a. Used as a metric of alcohol intoxication for legal or medical purposes.
   - ☐ b. A concentration of consumed of alcohol
   - ☐ c. The type of drinks consumed by a person
   - ☐ d. A chemical reaction of alcohol and person's blood type
8. A 180-pound person should wait for how long per ounce of consumed alcoholic beverage before driving?
   - ☐ a. 20 minutes
   - ☐ b. 45 minutes
   - ☐ c. 1 hour
   - ☐ d. Do not wait at all
9. Most people between the ages of 16 and 25 die from the following causes:
   - ☐ a. Traffic accidents
   - ☐ b. Suicide
   - ☐ c. Drug overdose
   - ☐ d. Robberies
10. Alcohol is the factor in approximately what percentage of fatal accidents?
   - ☐ a. 50%
   - ☐ b. 25%
   - ☐ c. 10%
   - ☐ d. Almost 75%

11. In the state of Illinois, which of the following Blood Alcohol Concentration (BAC) is considered
legally under the influence?

- ☐ a. 0.25%
- ☐ b. 0.08%
- ☐ c. 0.10%
- ☐ d. 0.11%

12. Which of the following methods is most recommended for sobering up after drinking more than 5
drinks in a night?

- ☐ a. Time
- ☐ b. There is no method of sobering up
- ☐ c. Drink a very strong cup of coffee
- ☐ d. None of the above

13. At which Blood Alcohol Concentration (BAC) does a person start experiencing difficulty in making rational decisions, concentrate on driving, and breaking in a normal manner?

- ☐ a. 0.01%
- ☐ b. 0.05%
- ☐ c. 0.08%
- ☐ d. 0.10%

14. What are the types of treatments available for Substance Use Disorder?

- ☐ a. Attendance of Alcoholic Anonymous Meetings
- ☐ b. Client treatment with a psychologist, counselor, or social worker
- ☐ c. Inpatient/Outpatient treatment
- ☐ d. All of the above

15. How can you determine what type(s) of drink(s) you should consume before driving?

- ☐ a. Never drink vodka, whiskey, scotch, or cognac
- ☐ b. Drink only wine or beer
- ☐ c. All of the above
- ☐ d. None of the above

16. What type(s) of alcoholic beverage(s) is/are most addicting?

- ☐ a. Spirits
- ☐ b. Wine
- ☐ c. Beer
- ☐ d. Cannot be determined because of many other factors that need to be taken into a ☐ consideration

17. How can you avoid driving while intoxicated after a party?

- ☐ a. Give your car keys to a friend who promises you not to drink at the party
- ☐ b. Avoid consuming alcohol at the party

- [ ] c. Do not drive to the party by yourself
- [ ] d. All of the above

18. What is/are the difference(s) between alcohol dependence and alcohol abuse?
    - [ ] a. Increased tolerance
    - [ ] b. Consumption of alcohol to avoid withdrawal symptoms
    - [ ] c. Multiple attempts to cut down alcohol consumption
    - [ ] d. All of the above
19. Which of the following is(are) considered stimulant(s)?
    - [ ] a. Caffeine
    - [ ] b. Cocaine
    - [ ] c. Alcohol
    - [ ] d. Heroin
    - [ ] e. A and B
    - [ ] f. A and C
20. Which of the following is(are) considered depressant(s)?
    - [ ] a. Alcohol
    - [ ] b. Heroin
    - [ ] c. Valium
    - [ ] d. Prozac
    - [ ] e. A and B
    - [ ] f. All of the above
21. The drugs known as stimulants
    - [ ] a. Have effects similar to alcohol
    - [ ] b. Activate the central nervous system
    - [ ] c. Always lead to addiction
    - [ ] d. Make a person finally feel happy
22. How many people who drive while intoxicated are caught by police?
    - [ ] a. There are no such cases
    - [ ] b. 1 in 2
    - [ ] c. 1 in 4
    - [ ] d. 1 in 3
23. A person who abuses alcohol
    - [ ] a. Might have an increase in tolerance to alcohol
    - [ ] b. Might experience problems at work and with family members
    - [ ] c. Might exhibit dangerous behaviors after consumption of alcohol

☐ d. All of the above

24. DUI is the leading cause of
    ☐ a. Fatal traffic accidents
    ☐ b. Traffic accidents
    ☐ c. None of the above
    ☐ d. A and B only

25. An individual can be convicted for driving under the influence if his/her blood alcohol concentration is?
    ☐ a. 0.05 or above
    ☐ b. 0.08 or above
    ☐ c. Above 0.08
    ☐ d. None of the above

26. What are the 5 stages of change?
    ☐ a. Precontemplation, contemplation, preparation, action, and maintenance
    ☐ b. Contemplation, preparation, action, maintenance, and relapse avoidance
    ☐ c. Precontemplation, preparation, action, maintenance, and relapse avoidance
    ☐ d. None of the above

27. Alcoholics
    ☐ a. Never function normally
    ☐ b. Can function normally after treatment
    ☐ c. Always need counseling
    ☐ d. Never relapse

28. Alcoholics Anonymous is a (n)
    ☐ a. Organization that requires a membership fee to join
    ☐ b. Self-help support group
    ☐ c. Only for men
    ☐ d. Promotes safe drinking habits

29. The following types of drugs taken in combination with alcohol can lead to a fatal outcome
    ☐ a. Barbiturates
    ☐ b. Benzodiazepines
    ☐ c. Stimulants
    ☐ d. Opiates
    e. All of the above

30. Which of the following is true about marijuana?
    ☐ a. Marijuana is a drug
    ☐ b. Marijuana leads to physiological addiction

- ☐ c. Marijuana leads to emotional addiction
- ☐ d. None of the above
- ☐ e. A and C only

31. Ecstasy or "X"
    - ☐ a. Belongs to the group of Amphetamines
    - ☐ b. Belongs to the group of Opiates
    - ☐ c. Belongs to the group of Depressants
    - ☐ d. Is very similar to alcohol

32. Antabuse
    - ☐ a. Enables people to drink less so they will become intoxicated faster
    - ☐ b. Prevents people from consuming any alcoholic beverages
    - ☐ c. Allows people to drink moderately
    - ☐ d. Does not have an effect if a person drinks wine

33. Alcohol
    - ☐ a. Has less effect on a person if he/she is eating because food slows the absorption of alcohol in the body.
    - ☐ b. Has more effect on a person if he/she is eating because food increases the absorption of alcohol in the body.
    - ☐ c. Has the same effect on a person regardless of whether the person is eating or ☐ drinking because food does not have an effect on the absorption of alcohol in the body.
    - ☐ d. Cannot be determined

34. At what BAC range is death possible?
    - ☐ a. 0.5 to 0.10
    - ☐ b. 0.11 to 0.20
    - ☐ c. 0.21 to 0.38
    - ☐ d. Death can occur at all BAC ranges given the circumstance of the individual

35. If you drive with a suspended license after receiving a DUI in Illinois what can occur?
    - ☐ a. You can be sentenced to 10 to 30 days in jail or up to one year in jail
    - ☐ b. You might not be able to reinstate your driver's license
    - ☐ c. You can be sentenced to 30 days of community service
    - ☐ d. All of the above

36. The prevalence of alcoholism in the US population is the following
    - ☐ a. Approximately 1% of all Americans suffer from Alcoholism
    - ☐ b. Approximately 5% of all Americans suffer from Alcoholism
    - ☐ c. Approximately 10% of all Americans suffer from Alcoholism
    - ☐ d. Approximately 15% of all Americans suffer from Alcoholism

37. Alcohol
    - ☐ a. Can be an effective stress-management method

- ☐ b. Reduces long term stress but not short term
- ☐ c. Reduces short term stress but not long term
- ☐ d. Does not reduce stress levels and is not an effective method to reduce stress levels

38. Alcoholism
    - ☐ a. Has an effect only on a person that is an alcoholic
    - ☐ b. Does not have an effect on one's family members
    - ☐ c. Affects the entire family
    - ☐ d. None of the above

39. Withdrawal from Alcohol is characterized by
    - ☐ a. Shakes, nausea, and tachycardia
    - ☐ b. Hallucinations
    - ☐ c. Elevated anxiety levels
    - ☐ d. All of the above
40. Tolerance to Alcohol is characterized by
    - ☐ a. A need to drink more due to a craving for alcohol
    - ☐ b. A need to drink more to achieve the desired effect of alcohol
    - ☐ c. None of the above
    - ☐ d. All of the above
41. If you feel too tired to drive, the best way to handle your exhaustion is to
    - ☐ a. Drink a lot of caffeine
    - ☐ b. Take a stimulant or upper
    - ☐ c. Have a drink to cheer up
    - ☐ d. Take a nap and not to drive
42. The most prevalent characteristic of alcoholics is
    - ☐ a. Denial
    - ☐ b. Admission of alcohol problems
    - ☐ c. Open discussion of their drinking habits
    - ☐ d. None of the above
43. Nicotine
    - ☐ a. Is not a drug
    - ☐ b. Can never be addicting
    - ☐ c. Enables a person to sober up after drinking
    - ☐ d. Is a drug having certain chemical properties which lead to addiction
44. Relapse
    - ☐ a. Can be prevented
    - ☐ b. Must be acknowledged but ignored
    - ☐ c. Not a serious threat to recovery

☐ d. All of the above

45. Put these drugs in order of addictiveness (D, E, A, B, C)

_____ a. Alcohol
_____ b. Marijuana
_____ c. Chocolate
_____ d. Heroin
_____ e. Nicotine

46. What drug that is popular on the club scene and among high school students causes definitive brain damage in rodents and monkey?

☐ a. Alcohol
☐ b. Ecstasy
☐ c. There is no such a drug
☐ d. Any substances lead to definitive brain damage

47. Individuals who begin using drugs/alcohol at an early age are more likely to become addicted.

☐ True
☐ False

48. According to the revised Illinois Law, the second DUI arrest is considered a felony?

☐ a. True
☐ b. True, depending on the circumstance surrounding your arrest (accident, etc)
☐ c. False
☐ d. None of the above

49. What county of the Chicago Area has the most lenient Judges?

☐ a. Cook County
☐ b. Lake County
☐ c. Will County
☐ d. You drink, you drive, you lose

50. Alcohol and drugs affect the following body organs

☐ a. Cardiovascular System
☐ b. Nervous system, including brain
☐ c. Digestive System
☐ d. All of the above