



FAMILY HISTORY QUESTIONNAIRE

Supervisor
Brian P. McGuire
 Clerk
Katy Dolan Baumer
 Assessor
Thomas S. Smogolski
 Trustees
Alisa "Lee" Beattie
Craig Essick
Eugene N. Martinez
Khaja Moinuddin
 Administrator
James C. Barr, MPA

The purpose of this questionnaire is to provide your therapist with information that can be of help with services to your family. Information you provide will be held in confidence and will not be shared without written permission. If you need more space to answer questions, please use the backside of the page.

Date: _____

CHILD WHO HAS BEEN REFERRED FOR THERAPY:

Child's Name _____

Birthdate _____ Age _____

Sex: _____ Race/Ethnic Origin (Circle one for child): African-American
 Asian/Pacific Islander
 M/F Bi-Racial Caucasian Hispanic
 Indian/American Native Other

Address _____

 (City/Zip)

WHO ELSE IS LIVING IN THE CHILD'S HOUSEHOLD?

First Name/Last Name	Relationship to Child	Occupations of Parents/Guardians	Birth date	Age

MEMBERS OF THE ABOVE CHILD'S IMMEDIATE FAMILY WHO LIVE ELSEWHERE (Include biological, adoptive, step, and foster parents and siblings):

First Name/Last Name	Relationship to Child	Birth date	Age

CURRENT PROBLEM

1. Describe in your own words what problems your family is experiencing:

2. What attempts have you made to solve the problems?

FAMILY HISTORY

1. Parents' marital/and other important relationship history:

MOTHER			FATHER		
Spouse/partner	Dates (from/to)	No. of Children by:	Spouse/partner	Dates (from/to)	No. of Children by:

2. List the Referred Child's previous residences (specify date and location):

3. Has the Referred Child lived with anyone outside his/her immediate family? (specify with whom and for how long):

4. Has anyone important to your child/family died? (please specify who/and when):

5. What, if any, religion does your family observe? _____

MEDICAL AND PSYCHIATRIC HISTORY

1. Do you have a family physician? Yes _____ No _____

2. Does your child or any family member have any current medical problems?
 Yes _____ No _____ If yes, please specify: _____

3. List any family members currently taking medication:

Name	Medication	Amount	Prescribed by	Since When

4. During the last 6 months has your child or any family member had any significant changes (i.e., sleeping, weight, mood, concentration, etc)? Please specify who and what kind of changes:

5. Has your child or another family member been psychiatrically hospitalized? Please list name, hospital and dates: _____

6. Has your child or another family member been in counseling or psychotherapy before?
 Yes _____ No _____

Name	Agency/Therapist	Dates	Did it help?

SCHOOL HISTORY

1. Circle highest grade completed by each parent:

Mother: Elementary High School GED College Graduate
 012345678 9 10 11 12 13 14 15 16 17 18 19 20

Father: Elementary High School GED College Graduate
 012345678 9 10 11 12 13 14 15 16 17 18 19 20

2. Circle highest grade completed by other adult caregivers in the child’s household:

_____ : Elementary High School GED College Graduate
 (adult caregiver) 012345678 9 10 11 12 13 14 15 16 17 18 19 20

_____ : Elementary High School GED College Graduate
 (adult caregiver) 012345678 9 10 11 12 13 14 15 16 17 18 19 20

3. Did your child attend preschool? Yes _____ No _____

4. Describe your child’s overall academic performance since entering school:

	Below Average	Average	Above Average	Superior
Elementary				
Middle				
High School				

5. Has your child received special educational services? Yes _____ No _____
 Please specify: _____

6. Has your child received services from the school social worker? Yes _____ No _____

7. Has your child been tested by the school (i.e., educational test, psychological)? When and what test? _____

8. Why did the school want to test your child? _____

9. Has there been a change in your child's academic performance or school behavior in the past year?

COURT STATUS

1. Please indicate the current/and past legal status of any family member (specify dates):

Name	Pending	Supervision	Probation	Prison	Parole

2. Specify any circumstances if you wish: _____

PLEASE LIST ANY OTHER INFORMATION THAT YOU FEEL IS IMPORTANT:

Who participated in completing this form? _____

PLEASE GIVE THE FOLLOWING PHONE NUMBERS SO WE CAN REACH YOU:

Home Phone: _____ Work Phone: _____ Work Phone: _____
Area code/number (father) Area code/number (mother) Area code/number

THANK YOU VERY MUCH FOR YOUR TIME AND COOPERATION

Hanover Township Youth and Family Services Informed Consent and Confidentiality

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Informed Consent for Family Therapy or Other Services

Welcome to Hanover Township Youth and Family Services. Thank you for trusting us to assist you with your personal concerns. Please take the time to read and understand this document and ask your therapist about any portions which may be unclear to you.

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices. The accompanying Notice of Privacy Practices explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information before we provide any services. You may revoke this Agreement in writing at any time.¹

Services Offered

Hanover Township Youth and Family Services provides outpatient treatment services to Hanover Township residents. We serve families with children between the ages of 0 to 19. Masters level therapists conduct assessments, provide individual, couple, family and group therapy and offer case coordination as needed. Therapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Therapy calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during sessions and at home.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

In your first session your therapist will offer you some sense of what therapy will entail and how she or he will work with you to address your concerns. You should evaluate this information and whether you feel comfortable working with your therapist. If you have questions about our procedures, you should discuss them with your therapist whenever they arise. You have the right

to ask for the rationale for any aspect of your treatment or to decline any part of your treatment. Hanover Township Youth and Family Services does not use a DSM-IV-R diagnosis code for treatment which may be used in judicial or quash judicial proceedings, or insurance purposes. Nor can your therapist give you legal opinions. If you require a DSM-IV-R diagnosis and/or a therapist that can be used in judicial or judicial quash proceedings, Hanover Township Youth and Family Services will be happy to refer you to an appropriate service provider to help meet your needs.

Fees

We charge fees for treatment services. We do not bill insurance companies for treatment services. There is no charge for the screening appointment, community education presentations, and some groups. Although the actual cost per session is over \$75, the fee charged to the client may be partially waived according to the gross household income, and the number of persons dependent on the income. Fees will be set by your assigned therapist and you at the first regular treatment session and will begin with that first session. A fee agreement will be signed by you and your therapist. Approval of the Clinical Director may be necessary in special situations. No one will be refused service due to inability to pay. You are expected to pay your fee to the receptionist before each session. Checks are to be written to Hanover Township Youth and Family Services. A receipt will be given to you at the time of payment. Bills will not be mailed to you, though you may request a copy of your billing statement. Your therapist receives a copy of your fee receipt and will talk with you directly if you fail to pay your fee. Failure to pay the agreed upon fee could result in termination of the therapy. Returning clients are required to pay any unpaid balance.

Cancelled and missed appointments

If you are unable to come for a scheduled session you are expected to phone to cancel no later than 24 hours in advance. You will be charged your usual fee if you do not cancel within 24 hours, or if you fail your session without any notice. You are encouraged to discuss any special situations with your therapist as soon as possible.

In an Emergency

In some instances, you might need immediate help at a time when your therapist is not at Hanover Township Youth and Family Services or cannot return your call. These emergencies may involve suicidal thoughts, thoughts of wanting to hurt someone else, or thoughts of committing dangerous acts. If you find yourself in any emergency situation when the agency is closed, call our crisis line at 847-742-4199. If for whatever reason that option is not available to you, visit the nearest Emergency Room and ask for the mental health professional on call.

Limits of Confidentiality

The law protects the privacy of all communications between a client and a therapist, with certain exceptions discussed below. In most situations, we can only release information about your

treatment to others if you sign a written authorization form. There are other situations that require only that you provide written, advance consent. Your signature on the accompanying Acknowledgment of Informed Consent to Treatment form provides consent for those activities, as follows:

- We train graduate students from the mental health professions, and also employ therapists who are not yet licensed in Illinois. Licensed therapists on our staff supervise them, which includes reviewing treatment plans and progress, and signing off on all notes and other documents that go into your permanent file. You have the right to know the name of any supervisor and how to contact her or him; the staff member you meet with will provide this information at the outset.
- Your therapist may also occasionally find it helpful to consult with other Hanover Township Youth and Family Services professional staff members about a case. If you don't object, your therapist will not tell you about these consultations unless he or she feels that it is important to your work together. Your therapist will note all consultations in your Clinical Record.
- Finally, we employ administrative staff and we need to share protected information with them for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside Hanover Township Youth and Family Services without the permission of a professional staff member.

There are some situations where we are permitted or required to disclose information either with or without your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, we generally cannot provide Mental Health Records (MHR) without your (or your legal representatives) written authorization, and/or a court order from a judge.
- If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.
- If your clinical record is made part of a civil or criminal court proceeding, that file may become part of the public record, and can be retrieved by any person who requests it.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a client files a complaint or lawsuit against a therapist, we may disclose relevant information regarding that client in order to defend the therapist.
- If a client files a worker's compensation claim, we must, upon appropriate request, provide a copy of the client's record or a report of her/his treatment.

There are some situations in which the therapist is legally obligated to take actions which she or he believes are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

- If your therapist has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency.
- If the therapist believes you present a clear and substantial danger of harm to yourself or another/others, he or she will take protective actions. These may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and notifying the police.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read our Notice of Privacy Practices for more detailed explanations, and discuss with the staff member you meet with any questions or concerns you may have.

Professional Records

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We therefore recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of \$.10 per page after the first 50 pages, for which there is no cost. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, your therapist may also keep a set of therapy notes which are for his or her own use and designed to assist your therapist in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to others with your Clinical Record, except under rare legal circumstances.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

In Conclusion

Your signature on the accompanying Acknowledgement of Informed Consent to Treatment form indicates you have read the information in this document and agree to abide by its terms during our professional relationship.

Acknowledgement of Consent for Treatment

I have read and understand the Informed Consent for Family Therapy and Other Services and Notice of Privacy Practices. My signature below indicates that I give my full and informed consent to receive services at Hanover Township Youth and Family Services. I understand that if I do not consent to treatment Hanover Township Youth and Family Services cannot provide services.

Client (age 18 and over) Date

Client (age 18 and over) Date

Client (age 18 and over) Date

Client (age 12 through 17) Parent/Guardian Date

Client (age 12 through 17) Parent/Guardian Date

Client (age 12 through 17) Parent/Guardian Date

Client (under age 12) Parent/Guardian Date

Client (under age 12) Parent/Guardian Date

Client (under age 12) Parent/Guardian Date

Witness Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed by Hanover Township Youth and Family Services and how you can get access to this information. Please review this notice carefully.

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Understanding Your Protected Health Information (PHI)

When you visit us, a record is made of your symptoms, assessments, treatment plan, and other mental health or medical information. Your record is the physical property of Hanover Township Youth and Family Services, the information within which belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosure to others. In using and disclosing your protected health information (PHI), it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirements of Illinois law.

Your mental health and/or medical record serves as

- a basis for planning your care and treatment
- a means of communication among the health professionals who may contribute to your care
- a legal document describing the care you received
- a means by which you or a third-party payer can verify that services billed were actually provided
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of Hanover Township Youth and Family Services

We are required to:

- Maintain the privacy of your protected health information (PHI) as required by law and provide you with notice of our legal duties and privacy practices with respect to the protected health information that we collect and maintain about you.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy, upon request.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests to communicate with you about protected health information by alternative means or at alternative locations, e.g. you may not want a family member to know that you are being seen at Hanover Township Youth and Family Services. At your request, we will communicate with you, if needed, at a different location.
- Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights

You have the right to:

- review and obtain a paper copy of the notice of privacy practices upon request and of your health information, except that you are not entitled to access, or to obtain a copy of, therapy notes and a few other exceptions may apply. Copy charges may apply.
- request and provide written authorization and permission to release information for purposes of outside treatment and health care operations. This authorization excludes therapy notes and any audio/video tapes that may have been made with your permission by your mental health clinician.
- revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
- request a restriction on certain uses and disclosures of protected health information, but we are not required to agree to the restriction request. You should address your restriction request in writing to Hanover Township Youth and Family Services Director. We will notify you within 10 days if we cannot agree to the restriction.
- request that we amend your health information by submitting a written request with the reasons supporting the request to Hanover Township Youth and Family Services Director. We are not required to agree to the requested amendment.
- request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment and Health Operations

I. Hanover Township Youth and Family Services will use your PHI, with your consent, in the following circumstances:

Treatment: Information obtained by your therapist will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.

For health care operations. Members of Hanover Township Administration may use information in your health record to assess the performance and operations of our services. This information will then be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.

Disclosure to others outside of Hanover Township Youth and Family Services: If you give us a written authorization, you may revoke it in writing at any time, but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except as described below to report serious threat to health or safety or child and adult abuse or neglect.

II. Hanover Township Youth and Family Services will use your PHI, without your consent or authorization, in the following circumstances:

Child Abuse: If we have reasonable cause to suspect that a child known to us in the course of professional duties has been abused or neglected, or have reason to believe that a child known to us in the course of our professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, we must report this to the relevant county department, child welfare agency, police, or sheriff's department.

Adult and Domestic Abuse: If we believe that a vulnerable adult (ex. incapacitated or facility resident) is the victim of abuse, neglect or domestic violence or the possible victim of other crimes, we may report such information to the relevant county department or state official.

Serious Threat to Health or Safety: If we have reason to believe, exercising best judgment and our professional care and skill, that you may cause serious harm to yourself or another person, we may take steps, without your consent, to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition in order to protect you or another person from harm. This may include instituting commitment proceedings.

Judicial or administrative proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release the information without written authorization from you or your personal or legally-appointed representative, or a subpoena/court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered.

As required by law for national security and law enforcement: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information for law enforcement purposes as required by law or in response to a valid court order.

Law/Health Oversight: As required by law we may disclose your health information. For example, if the Illinois Department of Professional Regulations requests that we release records to them in order to investigate a complaint against a provider, we must comply with such a request.

Workers Compensation: We may disclose health information to the extent authorized by you and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law; we may be required to testify.

As required by law for purposes of public health: e.g. as required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Business Associates: There are some services provided to Hanover Township Youth and Family Services through contracts with business associates. Examples include computer support for our scheduling system. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we've asked them to do. Business associates are required to safeguard your information.

For More Information or to report a problem

If you have questions and would like additional information, please ask your clinician. He/she will provide you with additional information or put you in contact with the Director of Hanover Township Youth and Family Services, John Parquette, LCSW at 630-483-5799.

If you are concerned that your privacy rights have been violated, or if you disagree with a decision we have made about access to your health information, or if you would like to make a request to amend or restrict the use or disclosure of your health information, you may contact:

Tina Houdek, Director, Hanover Township Youth and Family Services, 250 S. Rt. 59, Bartlett, IL 60103 Phone: (630) 483-5799 Fax: (630) 483-5789

If you believe that your privacy rights have been violated, you can also file a complaint with the Secretary of the U.S. Department of Health and Human Services:

Office for Civil Rights

U.S. Department of Health & Human Services

150 S. Independence Mall West - Suite 372

Philadelphia, PA 19106-3499

(215) 861-4441; (215) 861-4440 (TDD) Fax: (215) 861-4431

You may also visit this web site for forms: <http://www.hhs.gov/ocr/privacyhowtofile.htm>

Hanover Township Youth and Family Services respects your right to the privacy of your health information. There will be no retaliation in any way for filing a complaint with us or the U.S. Department of Health and Human Services.