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ROSECRANCE AND AFFILIATES
Financial Release of Information

Client Name: _____ Client ID: _____ Client DOB:_____

Release of Information
This release of information is to secure payment for services provided by Rosecrance Health Network and Affiliates ("Rosecrance") and applies to the following information: *your presence in treatment; your demographic and medical information; treatment information and records including assessment, diagnosis, treatment plan, dates of service, type of service and level of care received; financial information; and any other information that is necessary to obtain authorization for services, to determine eligibility, to coordinate benefits, to submit health care claims, and to obtain reimbursement from a third-party payer or funding source.*

Indicate which of the following entities, payers, or funding sources are allowed to exchange information with Rosecrance:

X	Name	Description
		Parent/Guardian/Spouse
		Parent/Guardian
		Third Party Payer
		Third Party Payer
	Iowa Medicaid Enterprise (IME), Amerigroup Iowa ("Medicaid")	**Third Party Payer**
	Centers for Medicare & Medicaid Services ("Medicare")	**Third Party Payer**

Insurance Plan Information
I hereby authorize my plan administrator, the plan fiduciary, the insurer, and my attorney to release to Rosecrance any and all Plan documents, summary plan benefit description, insurance policy, medical necessity criteria, reasons for denial, and settlement information upon written request from Rosecrance or its attorneys in order to claim benefits or to pursue any internal or external appeal or legal or administrative remedies.

Parent Companies and Subsidiaries
I authorize Rosecrance to exchange information with the entities listed above and any wholly owned subsidiaries owned by that entity who are involved in processing claims and handling my insurance benefits.

Purpose and Condition
The purpose of this disclosure of information is for Rosecrance to obtain authorization and payment for treatment services provided to the client. I understand that treatment is being provided to the client in reliance on obtaining payment for services rendered.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Medical Records Department at Rosecrance. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration and Redisclosure
Unless sooner revoked, this consent expires one year after the last date on which services were provided, or until all claims relating to my treatment are paid in full, whichever is later. State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or Iowa Code Chapter 228.

_____ _____
Signature of Client Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ _____
Name of Parent, Guardian or Personal Representative (Print) Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)._____

THIS FORM MEETS ALL REQUIREMENTS OF 42 CFR PART 2, IOWA CODE CHAPTER 228, AND 45 CFR PARTS 160 & 164 (HIPAA)

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ROSECRANCE AND AFFILIATES
Assignment of Benefits / Guarantee of Payment

Client Name: _____ Client ID: _____ Client DOB:_____

Financial Responsibility

I acknowledge and agree:

- That I am financially responsible for all charges for services provided.
- That some or all of the services provided to the client by Rosecrance may not be covered by insurance.
- That I am responsible for all charges for services provided to the client listed above which are not covered by insurance or that are required under my Insurance Plan, such as co-payments or deductibles.
- That Rosecrance may be in-network or out-of-network and I will be responsible for additional charges not covered by policy.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Rosecrance.
- That Rosecrance will verify benefits prior to starting treatment and will share the information with me, but this does not guarantee payment. My insurance company's failure to process claims according to the verification of benefits information provided does not indicate an error by Rosecrance.
- That misrepresentation of insurance information may make me legally responsible for payment to Rosecrance.
- That I am responsible for keeping my insurance information up to date.

_____ _____

Name of Financially Responsible Person Signature of Financially Responsible Person Date

Assignment of Benefits

In exchange for and consideration of services provided by Rosecrance to the client listed above and to provide timely and accurate payment for such services:

- I certify that the information given by me for purposes of payment for the client's treatment at Rosecrance is, to the best of my knowledge, **complete and accurate and that no other coverage or insurance exists**.
- I assign my right to receive payment of authorized benefits to Rosecrance.
- I also assign and convey to Rosecrance all rights, powers, authority, and standing to pursue amounts owed under my health insurance plan and to pursue vindication of my rights under my health insurance plan or federal or state law incurred as a result of the treatment I receive from Rosecrance (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal or administrative claims.
- I authorize Rosecrance to file an appeal on my behalf for any denial of payment or adverse benefit determination.
- If my Insurance Plan will not direct payment to Rosecrance, I agree to endorse and forward to Rosecrance all health insurance payments, which I receive for the services rendered by Rosecrance and its health care providers and I agree that I am personally liable to Rosecrance for such monies.
- I understand that Rosecrance would not have accepted the undersigned as a patient, except for this assignment and guarantee of payment.
- If my current health insurance plan prohibits assignment of benefits, I hereby instruct my plan to provide documentation demonstrating such non-assignability to myself and Rosecrance. Failure to provide such documentation within thirty days of receipt of the claim submission shall constitute consent to and assignment and/or knowing and intentional waiver of any non-assignability clause by the plan. Acceptance of a claim submission from Rosecrance, or issuance directly to Rosecrance of an explanation of benefits, remittance advice, determination letter, or other decisional communication concerning the claim, shall be deemed to be consent to assignment or waiver of any non-assignability clause by the plan, its fiduciaries, and/or its third-party administrators.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I intend by this assignment and designation of authorized representative to convey to Rosecrance all my rights to claim the benefits related to services provided by Rosecrance, including rights to any settlement, insurance, or applicable legal or administrative remedies (including claims brought pursuant to state law, federal law or the provisions of ERISA, whether such claims seek benefits, statutory penalties, or prospective, retrospective, monetary, legal, equitable, or other relief, including without limitation claims for breach of fiduciary duty or claims related to the Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act") or any state law

equivalent of the Parity Act). Rosecrance is given the right by me (1) to obtain information regarding the claim to the same extent as me including the summary plan description, certificate of coverage, or other document setting forth the terms of the plan or under which the plan is operated; (2) to submit evidence; (3) to make statements about facts or law; (4) to make any request, including providing or receiving notice of appeal proceedings; (5) to participate in any administrative and judicial actions and to pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. As my assignee and my designated authorized representative, Rosecrance may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. I instruct Rosecrance to use whatever funds may be recovered as a result of actions brought on my behalf to reduce or eliminate any debt I may owe to Rosecrance and any related debt owed by Rosecrance for expenses incurred whilst seeking full reimbursement from my insurer, employer benefit plan, or third-party administrator.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

_____	_____	
Name of Client/Parent/Guardian	Signature of Client/Parent/Guardian	Date

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ROSECRANCE AND AFFILIATES
CONSENT FOR TREATMENT

Client Name: _____ Client ID: _____ Client DOB: _____

CONSENT TO TREATMENT

I consent to care and treatment by Rosecrance, Inc., its affiliates, and its employees. I also consent to treatment and care by physicians, behavioral health providers, and healthcare providers who are not employees or agents of Rosecrance, but are authorized by Rosecrance to provide treatment and care to me ("Rosecrance Providers"). I understand that my care team at Rosecrance may include resident physicians and students or other trainees.

I understand that my treatment and care will include mental health or substance use disorder treatment, including but not limited to group, individual, and family counseling; family program; educational lectures; recreational and art activities; and AA/NA/CA meetings. I understand that Rosecrance is an integrated behavioral health system with multiple treatment programs. By signing this form, I understand I am consenting to treatment in any program recommended by my Rosecrance providers.

I acknowledge that the specific benefits and risks of treatment; factors influencing the likelihood of success; treatment alternatives; and my right to refuse treatment services have been explained to me. I acknowledge that sufficient information and explanation concerning the nature and purpose of Rosecrance treatment programs, the procedures, and methods of treatment have been explained to me in order for me to make an informed judgment about my treatment. I am aware that mental health and substance use disorder treatment is not an exact science, and I acknowledge that no one has made any guarantees about the results of my treatment.

INDEPENDENT PHYSICIANS

I have been informed and understand that most physicians providing services at Rosecrance are not employees, agents or apparent agents of Rosecrance, but instead are independent medical practitioners who are responsible for their own judgment or conduct. These independent medical practitioners are not employees of Rosecrance and Rosecrance is not responsible for their actions. A list of physicians who are independent medical practitioners will be provided upon request.

VOLUNTARY NATURE OF PROGRAM

I voluntarily consent to treatment at Rosecrance and that the success of my treatment rests in my willingness to cooperate with the treatment process. I acknowledge that I may leave treatment at any time. I hereby release Rosecrance from all responsibility for any acts or consequences, medical or otherwise, which may result from my leaving treatment without authorization.

ROSECRANCE RULES

Upon admission, I received a Treatment Guide. I agree to cooperate and abide by all Rosecrance Rules contained in the Treatment Guide. I understand that Rosecrance may terminate services if I fail to engage in services, if I do not attend scheduled appointments, if I do not follow treatment recommendations, or if I fail to comply with all rules in the Treatment Guide. I understand that, upon admission to Rosecrance residential services and from time-to-time thereafter, my person and property will be searched for contraband. While in treatment, all alcohol, drugs, medications without appropriate prescription, or drug paraphernalia in my possession and/or brought onto Rosecrance property will be destroyed.

CLIENT RIGHTS AND CONFIDENTIALITY

I have had my client rights and responsibilities explained to me. I have been given a copy of and clearly understand the statement that describes the rights I have in treatment. I understand that my treatment at Rosecrance is subject to strict federal and state confidentiality laws.

During the program, such as in group sessions, I may learn confidential information about other clients in treatment. I agree to keep all information about other clients, including their participation in the program, in the strictest confidence.

PERSONAL PROPERTY AND ROSECRANCE PROPERTY

I understand that Rosecrance is not responsible for personal property that is lost, stolen, damaged, or left behind. I accept responsibility for any damage or destruction that may occur to Rosecrance property as a result of my behavior while I am a Rosecrance client.

RELEASE OF LIABILITY

I understand that part of my treatment may involve activities including but not limited to: 1) use of fitness/gym equipment, 2) participation in sports and recreational activities, 3) participation in experiential therapies, and 4) transportation by Rosecrance ("Activities"). These Activities involve the risk of accident, personal injury, and property damage. I understand that I can refuse to participate in these Activities. I agree for myself, my heirs, assigns, or representatives to waive, release, and forever discharge Rosecrance, its affiliates, and its employees from and against any and all claims, liabilities, and causes of action, whether foreseeable or unforeseeable should any accident occur involving personal injury or property damage during my participation in treatment.

CONSENT TO VIDEOTAPE / AUDIOTAPE

I understand that some Rosecrance facilities may employ video surveillance equipment for security monitoring purposes. I further understand that it is possible that my image will be captured by that equipment and that such images are protected by state and federal confidentiality laws. I also understand that some of my treatment sessions may be audio taped for internal performance improvement and quality assurance.

I understand that if I am under the age of 18 and leave Rosecrance against medical advice that my photograph may be released to law enforcement authorities.

CONSENT FOR ELECTRONIC COMMUNICATION

I give my consent for Rosecrance to communicate with me electronically via email, voicemail, or text message. I understand and acknowledge that there are risks inherent in the electronic transmission of unencrypted information over the internet or cellular networks and that such communications may be lost, delayed, intercepted, corrupted, or otherwise not delivered. I understand I may revoke this consent in writing to the Medical Records Department at Rosecrance at any time. In the case of a crisis or emergency, email and text message communication is not an appropriate method of reaching Rosecrance staff.

☐ **Yes** ☐ **No**

Appointment Communication Preference: ☐ **Home Phone** ☐ **Cell Phone**

Appointment Reminder Preference: ☐ **Voicemail** ☐ **Text**

AUTHORIZATION FOR MEDICAL AND DENTAL TREATMENT AND FINANCIAL RESPONSIBILITY

I authorize Rosecrance to seek and refer to medical or dental treatment as deemed appropriate and necessary by Rosecrance staff. I understand Rosecrance utilizes third party services for laboratories, pharmacies, and other medical services and these services represent an additional cost that I am responsible for. If I require emergency services while receiving treatment, I will be responsible for any costs charged by third parties who provide these emergency services. Rosecrance is not responsible for the actions and decisions of third party providers.

I certify that I have read the above form, that I understand its contents, and that I have asked all questions I have about this form. I agree to be bound by the terms of this consent form.

Client Name (Please Print)	Client ID#	Client DOB

Client Signature	Date

Parent/Guardian Signature, *if applicable*	Date

Staff Witness Signature	Date

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ROSECRANCE AND AFFILIATES
Authorization to Release Information

Client Name: _____ Client ID: _____ DOB: _____

I authorize Rosecrance Inc. and its Affiliates ("Rosecrance") to communicate with, release information to, and obtain records and information from:

Name:	Relationship:	Address:	Contact Information:

Purpose of Release:
The purpose of this disclosure of information is to share treatment information and to coordinate care. If other purpose, please specify: _____.
In the event of a disclosure necessary for emergency notification, Rosecrance will disclose that the client is participating in treatment.

Information to be Disclosed: ☐ **Complete Record**

- ☐ Medical/Psychiatric/Medication
- ☐ Lab Reports
- ☐ Assessments
- ☐ Progress Notes
- ☐ Treatment Plans/Treatment Plan Reviews
- ☐ Discharge Summaries
- ☐ Presence in treatment only
- ☐ Other _____

Specific Authorization
I specifically authorize the release of the information below (initial):

Mental Health ____ Substance Use Disorder ____ HIV ____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Rosecrance Medical Records Department. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
This authorization will expire on the following date: _____. If I do not specify an expiration date, this authorization will expire one year from the date of execution of this authorization.

Conditions
I further understand that if I refuse to sign this authorization, the consequence will be that no information will be disclosed. Rosecrance will not condition my treatment on whether I give authorization for the requested disclosure. I also have a right to inspect and copy the information that is to be released.

Form of Disclosure
We reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, by facsimile, or electronically. Rosecrance does not use encryption technology for e-mail and therefore, information being transmitted via email may be viewed by unauthorized persons during transmission. I understand that it may be impossible to determine whether unauthorized access to e-mail has taken place. In addition, e-mail usage may be monitored by Rosecrance administration for internal security purposes.

Redisclosure
Federal and State law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 and Iowa Code Chapter 228.

_____ _____ _____ _____
Signature of Client Date Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

THIS FORM MEETS ALL REQUIREMENTS OF 42 CFR PART 2, IOWA CODE CHAPTER 228, AND 45 CFR PARTS 160 & 164 (HIPAA)

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ROSECRANCE AND AFFILIATES
Acknowledgement & Receipt of Notice, Rights, Guide & Advanced Directives

Client Name (Print):_____ Client ID #:_____ DOB:_____

Notice of Privacy Practices - Receipt and Acknowledgment of Notice

I acknowledge that I have received and have been given an opportunity to read a copy of Rosecrance and Affiliates' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact: Rosecrance Inc. Privacy Officer at 1021 N. Mulford Road, Rockford, IL 61107, at (815) 387-5600, or via email at privacy@rosecrance.org

Client Signature: _____ Date: _____

Parent/ Guardian Signature *(if applicable)*: _____ Date: _____

Client Rights and Responsibilities

I acknowledge that I have received a copy of the Rosecrance and Affiliates' Client Rights and Responsibilities Form and that my rights and responsibilities have been explained to me. I understand my rights and responsibilities and know that if I have any questions, I may contact the Director of my program or speak with a Patient Advocate.

Client Signature: _____ Date: _____

Parent/ Guardian Signature *(if applicable)*: _____ Date: _____

Client Treatment Guide - Receipt and Acknowledgment of Guide

I hereby acknowledge that I have received a copy of and will be given an opportunity to read the Rosecrance Client Treatment Guide, which includes HIV / TB risk reduction information, program rules, and financial responsibilities. I understand that if I have any questions regarding the contents of the Treatment Guide, I can contact Rosecrance staff for further explanation.

Client Signature: _____ Date: _____

Parent/ Guardian Signature *(if applicable)*: _____ Date: _____

Residential Treatment ☐ N/A

For Adult and Adolescent Residential Substance Abuse Client: I further acknowledge that I agree to the use of the *Rosecrance Level System*, which is described in the treatment guide. ☐ Yes ☐ No

For Residential Clients: I further acknowledge that I have received the Rosecrance policy on restraint and seclusion. ☐ Yes ☐ No ☐ N/A

For parent / guardian of adolescents admitted for Residential Services: I further acknowledge that at residential admission I have received the Rosecrance policy on restraint and seclusion. ☐ Yes ☐ No ☐ N/A

Client Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Mental Health Adult Clients Only: ☐ N/A

Notice of Policy on Declaration for Mental Health Treatment (described in Client Treatment Guide)
Receipt, Acknowledgement of Notice, and Agreement to Terms

Do you have a Declaration for Mental Health Treatment? ☐ Yes ☐ No

I acknowledge I have been informed that Rosecrance will comply with my Declaration for Mental Health Treatment. I understand that if I have a declaration and have informed Rosecrance of this declaration, Rosecrance will maintain a copy in my medical record and will furnish a copy to emergency personnel.

Client Signature: _____ Date: _____

Parent/ Guardian Signature *(if applicable)*: _____ Date: _____

Witness Signature: _____ Date: _____

Residential Adult Clients Only: ☐ N/A

Notice of Policy on Advance Directives regarding cardiopulmonary resuscitation (CPR) including Do-Not-Resuscitate (DNR) Advance Directives, Practitioner Orders for Life-Sustaining Treatment (POLST) Form, or Physician Orders for Scope of Treatment (POST) Form (described in Client Treatment Guide)
Receipt, Acknowledgement of Notice, and Agreement to Terms

Do you have a:	DNR Advance Directive	☐ Yes	☐ No
	POLST Form	☐ Yes	☐ No
	POST Form	☐ Yes	☐ No

Check one:

☐ I acknowledge that I have been informed that ***Rosecrance is unwilling to comply*** with advance directives declining CPR. I understand that if I have an advance directive and have informed Rosecrance of this advance directive, Rosecrance will maintain a copy in my medical record and will furnish a copy to emergency personnel, but will not comply with the advance directive. I agree to honor Rosecrance's policy concerning advance directives declining CPR and ***wish to be admitted*** as a Client to Rosecrance.

OR

☐ I acknowledge that I have been informed that ***Rosecrance is unwilling to comply*** with advance directives declining CPR. I am requesting that my advance directive declining CPR be honored. Therefore, I also acknowledge that, because of Rosecrance's policy concerning advance directives declining CPR, ***I cannot be admitted***. I understand that Rosecrance will refer me to another facility.

Client Signature: _____ Date: _____

Parent/ Guardian Signature *(if applicable)*: _____ Date: _____

Witness Signature: _____ Date: _____

Rosecrance Staff Use Only

☐ Copy of: ☐ DNR/POLST/POST Form ☐ Declaration for Mental Health Treatment placed in client's chart.
☐ No copy of: ☐ DNR/POLST/POST Form ☐ Declaration for Mental Health Treatment received.

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ROSECRANCE AND AFFILIATES
Substance Abuse Client Rights & Responsibilities

As a client of Rosecrance and its Affiliates ("Rosecrance"), you, your parent or guardian, or authorized representative (if applicable) have a ***right*** to:

1. Have impartial **access to treatment** regardless of race, religion, gender, sexual orientation, religion, HIV status, age or disability.
2. Be provided services within the **least restrictive environment possible**, which assures your safety, health and well-being.
3. Have nondiscriminatory access to services and the right to have disabilities accommodated as specified in the Americans with Disabilities Act of 1990 (42 USC 12101).
4. Be informed regarding **confidentiality of HIV/AIDS** status and testing as well as the right to undergo testing on an anonymous basis.
5. Give or withhold informed consent regarding treatment and regarding confidential information about you.
6. File a client grievance or request to speak with a Patient Advocate if you disagree with a treatment decision or policy. Grievances will be addressed starting with a meeting with the program supervisor and up to the executive director.
7. Be informed about how to initiate a **complaint** and the appropriate means of requesting a hearing or review of the complaint.
8. Refuse treatment or any specific treatment procedure and a right to be informed of the consequences resulting from such refusal. If care, treatment, or services are refused, Rosecrance may terminate treatment and seek other alternatives.
9. Maintenance of privacy and **confidentiality** of all protected health information in your records per the Health Insurance Portability and Accountability Act, Iowa Code Chapter 228, and 42 CFR Part 2.
10. Be treated with **courtesy and respect** by all Rosecrance employees.
11. Be treated in a manner and in an environment free of neglect, exploitation, and verbal, mental, physical and sexual abuse.
12. Attend or refuse to attend **spiritual services** or to participate in religious activities or observe religious holidays within the framework of your interests, clinical status and treatment needs.
13. Amend your health information and obtain disclosures of protected health information.
14. **Emergency medical** care through direct care staff when applicable (CPR, First Aid) and community medical emergency services.
15. To be informed of your rights and responsibilities in a **language and manner** that meets your needs.
16. An **interpreter** where a language or communication barrier exists.
17. Be informed of the expectations for the level of **involvement and decisions** in your own care.
18. Assign a **surrogate decision maker** according to the Mental Health and Development Disabilities Code, the Power of Attorney for Health Care Law, or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act if you cannot understand a proposed treatment plan.
19. Formulate **advance directives** if so desired (adults only). Rosecrance is unable to comply with medical advance directives or Do Not Resuscitate Orders. If I have an advanced directive (i.e. a living will, durable power of attorney, etc.), Rosecrance will maintain a copy of the document in my medical record and furnish a copy to emergency personnel as necessary even though Rosecrance will not comply with the Advanced Medical Directive.
20. Right to involve family in decisions about treatment, care, and services and the right to visit with family, adult significant others, guardians, and support as services unless clinically contraindicated.
21. **Request the opinion of a consultant at your expense** or to request an in-house treatment plan review.
22. **Request an internal review of your plan of care, treatment, or services.**
23. Receive and understand an informed **consent** before participating in supplemental activities. This includes, but is not limited to the use of recordings, films or other images for internal use other than identification, diagnosis or treatment; recordings, film, or other images for external use; sports and exercise activities; community program involvement; volunteering; marketing; research studies; clinical trials; alumni activities.
24. Receive and understand an informed **consent** before you participate in any research project.
25. Be informed of the risks, side effects, and benefits of all **medications** and treatment procedures

26. **Refuse** specific medications, treatment, or intervention procedures, to the extent permitted by law, and to be informed of any consequences.
27. Send and receive mail without hindrance**.**
28. Be informed of the **hours of service**.
29. Individualized treatment including adequate and humane services regardless of the source(s) of **financial support**.
30. Receive considerate and respectful care in a safe **environment** that is mindful of your culture, values, and belief systems as well as your age and any disability.
31. Have personal **privacy** whenever possible.
32. Be informed of the **cost** of services rendered, and receive and examine your bill.
33. **Be informed that no use of chemical, physical or personal** restraints or seclusion **or locked units will be allowed.**
34. **Be informed about the** nature of the care**, procedures, and treatment that you will receive, as well as** alternatives **available.**
35. Have **access** to your clinical record and request that inaccuracies be corrected. If you believe the information in your record is inaccurate, you may respond to the Medical Records Department with a written statement which will then become part of your clinical record. If your request is denied, you may seek a court order to compel modification.
36. Actively **participate** in your treatment plan, treatment plan reviews, and discharge plan as appropriate to your age, maturity, clinical condition and involve family and significant others as you desire and/or guardian or authorized representative as regulated by law.
37. Have **access** to an individualized treatment plan, which will be developed and periodically reviewed with you and your family / significant other (if applicable). Additionally, you and your family / significant other (if chosen) will be included in planning your discharge.
38. Be involved in a **discharge/transition plan** that meets your continuing mental and physical health requirements following discharge.
39. A complete explanation for any **transfer** of treatment and knowledge of alternatives to that transfer.
40. Be informed if limitations exist to the duration and type of support and **ancillary services**.
41. Know the **rules** and regulations of the facility applicable to one's conduct.
42. Voice **concerns** or suggest changes in services and/or staff without being subject to threat, discrimination, coercion, reprisal, or unreasonable interruption of service for doing so.
43. Have all reasonable **requests** responded to promptly and adequately within the capacity of the treatment center.
44. Not be denied, suspended, terminated from services or have services reduced for **exercising any of these rights** except when the exercise of these rights prevents the provision of appropriate care.
45. Consult with legal counsel at any reasonable time.
46. Continuing contact with family and friends consistent with an effective treatment program during normal visiting hours. Visiting may be restricted if clinically warranted.
47. Conduct telephone conversations with family members and persons on the patient's approved phone list during reasonable hours. Use of the telephone may be restricted if clinically warranted.

As a client of Rosecrance, you have the ***responsibility*** for:

1. Providing to the best of your knowledge, accurate and complete information regarding past illnesses, hospitalizations, medications, psychosocial and other information relating to your health, including any cultural values or special communication needs. History of medical or psychiatric treatment, care or services.
2. Asking questions when instructions, plan of care, or expectations are not understood.
3. Participate in your care by following mutually agreed upon treatment plans.
4. Stating your expectations during care, service, or treatment plan development.
5. Cooperate and assist in making treatment plans in a responsible and timely manner.
6. Accepting the outcomes if the care, service or treatment plan is not followed.
7. Following Rosecrance policies, rules and regulations concerning individual care and conduct.
8. Showing respect and consideration of other clients and their property
9. Showing respect and consideration of Rosecrance staff and property
10. Helping control noise and disturbances
11. Following smoking policies

12. Promptly meeting any financial obligation agreed to with Rosecrance
13. Complying with safety rules and helping to maintain a safe environment; Reporting safety risks.
14. Carrying out personal housekeeping tasks without compensation.
15. Be responsible for the behavior of minor children you bring in to the agency.
16. Keep scheduled appointments or cancel them 24 hours in advance.
17. Keep information shared in therapeutic groups private and confidential.

The client has the right to contact the following agencies with questions about his or her rights of if there is a possibility the client's rights have been violated.

State of Illinois Guardianship & Advocacy Commission 4302 North Main Street Rockford, IL 61103 815-987-7567	Equip for Equality, Northwest Region Paddock Building 1612 2dn Ave. Suite 210 P.O. Box 3753 Rock Island, IL 61204 800-758-6869 TTY-800-610-2779
Department of Correction 1301 Concordia Ct. P.O. Box 19277 Springfield IL, 62703 800-368-1463	Department of Children & Family Services (DCFS) Office of Affirmative Action 100 West Randolph Chicago, IL 60801 312-814-4692
The Joint Commission Office of Quality and Patient Safety One Renaissance Boulevard Oakbrook Terrace, Illinois 60181 Fax: 630-792-5636	Illinois Department of Human Services Division of Alcoholism and Substance Abuse 100 W. Randolph St., Suite 5-600 Chicago, IL 60601 312-814-3840
Wisconsin Department of Safety and Professionals Services: Division of Legal Services and Compliance P.O. Box 7190 Madison, WI. 53707-7190 608-266-2112	Wisconsin Department of Health Services 1 West Wilson Street Madison, WI 53703 608-266-1865
Iowa Department of Public Health Division of Behavioral Health Lucas State Office Building 321 E. 12th Street Des Moines, IA 50319-0075	

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ROSECRANCE AND AFFILIATES
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected health information" or "PHI" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services. The confidentiality of mental health and alcohol and drug abuse client records is specifically protected by State and/ or Federal law and regulations. Rosecrance, Inc., Rosecrance Health Network, Rosecrance New Life, Rosecrance Jackson Centers, Inc. and Aspen Counseling & Consulting, LLC (collectively the "Covered Entities") are required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the program that you attend/attended the program or disclosing any information that identifies you as a mental health client or an alcohol or drug abuser. If you suspect a violation, you may file a report to the appropriate authorities in accordance with State and Federal regulations. Additionally, the Covered Entities included in this joint Notice will share protected health information with each other, as necessary, to carry out treatment, payment and healthcare operations. Covered Entities must legally maintain the privacy and security of your PHI and follow the duties and privacy practices described in this notice. Covered Entities will not use or share information other than as described here unless authorized in writing.

How We May Use and Disclose Health Information About You

- **For treatment.** We may use medical and clinical information about you to provide you with treatment or services, coordinating care, or managing your treatment. If you are a substance abuse client, we may disclose PHI to other providers after obtaining your authorization. If you are a mental health client, we may coordinate your care with other providers without authorizations. For example, Covered Entities may need to request a list of your current medications prescribed by your Primary Care Physician
- **For payment.** With your authorization, we may use and disclose protected health information about you so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.
- **For health care operations.** We may use and disclose your protected health information for certain purposes in connection with the operation of our program, including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.
- **Required by law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.
- **Without authorization.** Applicable law also permits us to disclose information about you without your authorization in a limited number of other situations, such as with a court order. These situations are explained below.

- **Health Oversight.** We may disclose PHI to a health oversight agency for activities authorized by law, such as for audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third party payors) and peer review organizations performing utilization and quality control. If we disclose PHI for substance abuse clients to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your information.
- **Public Health.** We may disclose your PHI for public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority. In certain circumstances outlined in the Privacy Regulations, we may disclose your PHI to a person who is subject to the jurisdiction of the Food and Drug Administration with respect to the reporting of certain occurrences involving food, drugs, or other products distributed by such person. In certain limited circumstances, we may also disclose your PHI to a person that may have been exposed to a communicable disease or may otherwise be at risk of spreading or contracting such disease, if such disease is authorized by law. For example, we may disclose PHI regarding the fact that you have contracted a certain communicable disease to a public health authority authorized by law to collect or receive such information.
- **Fundraising.** Covered Entities may use your protected health information to communicate with you to request a donation for a fundraising effort in support of or on the behalf of Covered Entities. You have the right to opt out of receiving fundraising communications. You can write to the Development Coordinator at 1021 N. Mulford Road, Rockford, Illinois 61107 or email giving@rosecrance.org with your request to opt out of future communications.
- **Program Evaluation.** We may use your protected health information to contact you for evaluation and follow-up studies conducted by Covered Entities staff in order to determine effectiveness of Covered Entities services. Covered Entities may also disclose PHI to external program evaluators (including the Secretary of HHS for HIPAA rules, compliance and enforcement purposes), with an agreement in place, if substance abuse records are requested to be sent to or taken with the evaluator.
- **Medical Emergencies**. We may use or disclose your protected health information in a medical emergency situation to medical personnel only and as legally permissible if you are a substance abuse client. If you are a mental health client, Covered Entities can disclosure your information in a medical emergency.
- **Coordination of Care**: For Mental Health clients, Covered Entities staff may disclose PHI for the purposes of continuity of care without consent. The purpose of coordination will be limited to admission, treatment, planning, coordinating care, discharge, or governmentally mandated public health reporting. For substance abuse clients and situations that are not emergencies, authorization is needed to coordinate care with third parties.
- **Mandated Reporting**. We may use your protected health information in order to comply with rules and regulations mandating Covered Entities staff to report to law enforcement or government agencies. Examples of situations where reporting may be necessary include abuse and neglect, FOID reporting to DHS, and duty to warn situations. Duty to warn situations occur when someone indicates a specific act of violence towards themselves or another individual.

- **Deceased Client.** We may disclose PHI regarding deceased clients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.
- **Research**. We may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations; and (d) the researchers agree not to redisclose your protected health information except back to Covered Entities.
- **Criminal Activity on Program Premises/Against Program Personnel**. If you are a substance abuse client, we may disclose your PHI to the law enforcement officials if you have committed a crime on program premises or against program personnel or have threatened to do so. If you are a mental health client, your information may be disclosed if Covered Entities believes a violation of criminal law or other serious incident has occurred in Covered Entities program.
- **Legal**. We may disclose your PHI to respond to lawsuits and legal actions. If you are involved in a legal issue where Rosecrance is not a party, Rosecrance may disclose your information with your authorization or court order for situations involving family matters, worker's compensation, civil actions, or other legal issues.
- **Court Order.** We may disclose your PHI if the court issues an appropriate order and follows required procedures.
- **Special Government Functions.** If you are an active military member or veteran, we may disclose your PHI as required by military command authorities. We may disclose your PHI to authorized federal officials for national security and intelligence reasons and to the Department of State for medical suitability determinations.
- **With authorization.** We must obtain written authorization from you for all other uses and disclosures of your PHI.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to the Medical Records Department at 2704 N. Main Street, Rockford, IL 61103. If you have any questions, you may contact the Privacy Officer at 815-391-1000.

- **Right to Revocation.** It is your right to revoke any authorizations, at any time by sending written notification to the Medical Records Department to the addresses listed above.
- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend**. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice**. You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 1021 North Mulford Road, Rockford, IL 61107, 815.391.1000. You may also file a complaint with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling 202.619.0257. We will not retaliate against you for filing a complaint.

Confidentiality of Alcohol and Drug Abuse Client Records

The confidentiality of alcohol and drug abuse client records is protected by additional Federal law and regulations. The Covered Entities are required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the Covered Entities that you attend a substance abuse treatment program or disclosing any information that identifies you as an alcohol or drug abuser. Some of the exceptions to this general rule include:

- The disclosure is allowed by a court order.
- The disclosure is made to medical personnel in a medical emergency.
- The disclosure is with your written consent

The violation of Federal laws or regulations by this program is a crime. If you suspect a violation you may file a report to the appropriate authorities in accordance with Federal regulations

Confidentiality of Mental Health Client Records

The confidentiality of mental health client records is protected by State law and regulations. The Covered Entities are required to comply with these additional restrictions. This includes a prohibition, with limited exceptions, on informing anyone outside the Covered Entities that you are a recipient of mental health treatment or disclosing any information that identifies you as a mental health client. Some of the exceptions to this general rule include:

- The disclosure is allowed by a court order.
- The disclosure is made to medical personnel in a medical emergency.
- The disclosure is with your written consent

- The disclosure for purposes of health information exchange, in accordance with the requirements of the Illinois Mental Health and Developmental Disabilities Confidentiality Act or Iowa Code Chapter 228. Unless you have chosen to opt-out of the health information exchange as specified in that Act.

The violation of State laws or regulations by this program is a crime. If you suspect a violation you may file a report to the appropriate authorities in accordance with State law.

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer:
Privacy Officer
1021 North Mulford Road
Rockford, IL 61107
815.387.5600

This Notice of Privacy Practices describes how we may use and disclose your protected health information ("PHI") in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice of Privacy Practices by posting a copy on our website: www.rosecrance.org, sending a copy to you in the mail upon request, or providing one to you at your next appointment.