Client Intake

Packet

Northeast DuPage Family & Youth Services

2025

Northeast DuPage Family & Youth Services Inc.

777 Army Trail Blvd.
Addison IL 60101-2787
6306937934

Northeast DuPage Family and Youth Services (NEDFYS)
1. Client Attendance & Cancellation Policy

At NEDFYS, we are committed to providing high-quality, accessible, and consistent services to all clients. To support the therapeutic process and ensure availability of services, we ask all clients to adhere to the following attendance and cancellation policy:

Policy Guidelines:

1. **Appointment Scheduling**
   Sessions are scheduled in advance with your clinician. It is your responsibility to attend all scheduled appointments or notify your clinician/our office at least 24 hours prior if you need to cancel.
2. **Cancellation Notice Requirement**
   If you need to cancel or reschedule an appointment, we ask that you provide **at least 24 hours' notice.**
3. **Late Cancellation / Missed Appointment Policy**
   - This policy shall be subject to annual renewal, effective twelve (12) months from the date of execution, at which time it shall be reviewed and reissued.
     i. **First Occurrence**: No fee will be charged. This will serve as a written warning and reminder of the policy.
     ii. **Second Occurrence**: A $**50 charge** will be billed to you.
         1. Failure to provide reimbursement of fees associated with the cancellation policy will result in no further scheduling of services until the balance is reinstated, if the outstanding balance exceeds sixty (60) days, this will result in termination of services.
     iii. **Third Occurrence**: Services will be **terminated** due to continued failure to attend scheduled sessions.
4. **No-Call/No-Show Policy**
   - This policy shall be subject to annual renewal, effective twelve (12) months from the date of execution, at which time it shall be reviewed and reissued. In addition, tardiness to appointments that exceeds fifteen (15) minutes without communication prior will be considered a no-call/no-show and processed accordingly.
     i. **First Occurrence**: A $50 charge will be billed to you.
         1. Failure to provide reimbursement of fees associated with the cancellation policy will result in no further scheduling of services until the balance is reinstated, if the outstanding balance exceeds sixty (60) days, this will result in termination of services.
     ii. **Second Occurrence**: Will result in termination of services.

5. **Billing Information**
    - All clients are responsible for providing Northeast DuPage Family & Youth Services (NEDFYS) with accurate billing information. If the client is under the age of eighteen (18), a legal guardian/parent/representative is obligated to present such information. All fees associated with the cancellation policy will be billed directly to the billing information on file, with the signature below acknowledging that NEDFYS will be billing in accordance with the cancellation policy.
6. **Emergency Exceptions**
   We understand that emergencies happen. Please communicate with your clinician as soon as possible if an unexpected situation prevents you from attending. Exceptions to the policy may be made at the organization's discretion.
7. **Reinstatement of Services**
   Clients whose services are terminated due to repeated cancellations or no-shows may contact NEDFYS to discuss possible re-engagement, subject to availability and clinical approval.

The signature below indicates that you have read, fully understand, and agree to the Client Attendance & Cancellation Policy provided by Northeast DuPage Family & Youth Services (NEDFYS).

Client Signature:_____

Date:_____

Northeast DuPage Family & Youth Services Inc.
777 Army Trail Blvd.
Addison IL 60101-2787
6306937934

0. Payment for Services Agreement - English

Client Full Name:

Northeast DuPage Family and Youth Services (NEDFYS) provides individual, family, and couples counseling at a rate of $200.00 for the first session and $180 for subsequent sessions.

Are you a parent/guardian completing agreement on behalf of a minor?:

If yes, please provide your name:

Please initial your payment selection/s and complete payment information

- [ ] I will not be using insurance and agree to pay $200 for the first session and $180 for subsequent sessions.
- [ ] I require a fee reduction. I have completed the Open Door: Sliding Fee Scale Application.

Insurance Information

- [ ] I will be using insurance or Medicaid. Please provide Insurance Card.

Primary Insured Name:

Relationship to Client:

Address (if different):

Phone Number:

Date of Birth of Insured:

Authorized Person’s Signature:

- [ ] I authorize the release of any medical or other information necessary to process claims.
- [ ] I authorize payment of medical benefits to NEDFYS for services rendered.

- [ ] I agree to pay the deductible, co-payment, or co-insurance as indicated by my insurance company at the time of service.
- [ ] I accept the financial responsibility of any balance remaining on the account after insurance has processed the claim.

Fee Assessment

I understand that fees are assessed yearly. I understand that if my financial situation changes, I must inform my therapist at the next scheduled session.

Canceled or Missed Appointments

Once an appointment is scheduled, that time is reserved just for you. If a scheduled appointment is missed or canceled with less than a 12-hour notice, there is a $25 fee.

Client Balances

I am aware that I am responsible for my session fee or insurance co-pay, co-insurance, or deductible at the time of service. I may pay with cash, check, or credit card. I understand there is a $30 returned check fee. If my account has an outstanding balance that has not had payment for three sessions, further sessions will not be scheduled unless approved by a supervisor.

Financial Communication

I authorize NEDFYS to provide all invoices and receipts via email.

Email:

I understand and agree to the financial policies as stated.

Client Signature:

Northeast DuPage Family & Youth Services Inc.

777 Army Trail Blvd.
Addison IL 60101-2787
6306937934

1. Release of Information (ROI) – Emergency Situations - English

Client Full Name:

Client ID Number:

Please provide at least one person we may contact in the event of an emergency involving your health, safety, or welfare.

Emergency Contact Name:

Relationship to Client:

Phone Number:

Alternate Phone Number:

Emergency Contact Consent

In the event of a mental health crisis, medical emergency, or concern for your safety, NEDFYS may need to contact the person listed above. Please check one:

- ☐ Yes, I authorize NEDFYS to contact this person in the event of an emergency.
- ☐ No, I do not authorize NEDFYS to contact this person.

Additionally, please check one:

- ☐ Yes, I authorize this person to be informed of clinical concerns during an emergency (including safety planning or coordination with emergency services).
- ☐ No, I do not authorize any clinical details to be shared with this person.

Release of Information (ROI) Authorization – Emergency Situations Only

By signing below, I authorize Northeast DuPage Family and Youth Services (NEDFYS) to disclose health and safety-related information to the individual named above in situations deemed an emergency, as defined under HIPAA and Illinois law. This authorization is limited to emergency circumstances and does not grant ongoing access to my medical record or clinical information. This authorization may be revoked in writing at any time, except where disclosures have already occurred.

Client's Name:

Parent/Legal Guardian's Guardian Name (if Client is a minor):

Northeast DuPage Family & Youth Services Inc.

777 Army Trail Blvd.
Addison IL 60101-2787
6306937934

2. Client Rights and Responsibilities Notice - English

Client Full Name:

Client ID Number:

Your Rights as a Client

As a client receiving services at Northeast DuPage Family and Youth Services (NEDFYS), you have the right to

1. Respect and Dignity

Be treated with compassion, dignity, and respect regardless of race, ethnicity, religion, gender identity, sexual orientation, disability, age, or source of payment.

2. Participation in Treatment

Actively participate in the development of your treatment plan and ask questions about services or goals.

3. Refusal of Services

Decline or discontinue services at any time, and understand the possible impact on your care.

4. Confidentiality

Have your personal health information protected under HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

5. Access to Your Records

Request access to your clinical records, subject to legal and clinical review for safety and appropriateness.

6. Continuity and Coordination of Care

Receive consistent care and be referred to other providers or services when necessary.

7. Telehealth and Communication Choices

Consent or decline the use telehealth services and electronic communication methods.

8. Freedom from Abuse or Coercion

Receive services in an environment free from abuse, neglect, coercion, or harassment.

9. Choice of Provider

Request a change of therapist or service provider at any time.

10. Consent and Informed Decision-Making

Be fully informed about the purpose, risks, benefits, and alternatives of treatment before consenting to services.

11. Interpreter Services

Receive services in your preferred language at no cost, including access to interpreter services and translated materials.

Would you like NEDFYS to provide an interpreter for your sessions at no cost to you?:

- [ ] No
- [ ] Yes

If so, please indicate your language/dialect:

12. Grievances and Complaints

If you are dissatisfied with any aspect of your services or if you believe your rights have been violated, you have the right to file a grievance or complaint without fear of retaliation.

You may file a grievance by:

● Speaking directly to your Therapist.

● Contacting the Clinical Manager or Compliance Officer

The Grievance Policy and Procedure can be found at www.NEDFYS.org

Your Responsibilities as a Client

In return, NEDFYS asks that you:

1. Attend Appointments

Make every effort to attend scheduled sessions and notify us in advance if you must cancel or reschedule.

2. Participate Actively

Engage in the therapy process, work collaboratively with your clinician, and follow agreed-upon treatment goals.

3. Communicate Honestly

Share openly about your needs, progress, or any problems related to your care.

4. Respect Staff and Other Clients

Maintain a respectful and safe environment for others in the office or group settings.

5. Provide Accurate Information

Update us on any changes in your health, insurance, contact information, or emergency contacts.

6. Follow Policies and Procedures

Cooperate with NEDFYS's policies, including safety protocols, confidentiality expectations, and billing procedures.

Cancelled or Missed Appointments

Once an appointment is scheduled, that time is reserved just for you. You will be charged a fee if a scheduled appointment is missed or cancelled with less than 24 hours' notice.

● First Occurrence: No fee will be charged. This will serve as a written warning and reminder of the policy.

● Second Occurrence: A $50 charge will be billed to you.
If the outstanding balance exceeds sixty (60) days, this may result in the termination of services.

● Third Occurrence: Services may be terminated due to continued failure to attend scheduled sessions.

No-Call/No-Show Policy

Tardiness to appointments that exceeds fifteen (15) minutes without prior communication will be considered a no-call/no-show and processed accordingly.

● First Occurrence: A $50 charge will be billed to you. If the outstanding balance exceeds sixty (60) days, this may result in the termination of services.

● Second Occurrence: Will result in termination of services.

Acknowledgement of Rights and Responsibilities

By signing below, I acknowledge that:

● I have received and reviewed my rights and responsibilities as a client of NEDFYS.

● I understand my role in the treatment process.

● I understand I may ask questions, request additional information, or file a grievance at any time.

Client's Name:

Parent/Legal Guardian's Name (if Client is a minor):

Date:

Northeast DuPage Family & Youth Services Inc.

777 Army Trail Blvd.
Addison IL 60101-2787
6306937934

3. Consent for IM+CANS Assessment - English

Client Full Name:

Client ID Number:

What is the IM+CANS?

The Integrated Assessment and Treatment Planning (IM+CANS) is a Medicaid-required tool used to understand your or your child's mental health, physical health, substance use, and social support needs. It combines clinical information to help develop an individualized treatment plan. Your responses are voluntary, but full participation helps ensure accurate planning and access to needed services.

At NEDFYS, the IM+CANS is used:

- To guide treatment decisions and services
- To fulfill Medicaid and managed care requirements
- To support coordination of care among providers (if applicable)

What Will Be Collected?

Information gathered may include:

- Medical and behavioral health history
- Family and social relationships
- Educational and occupational needs
- Risk behaviors and strengths
- Functional assessment and mental health diagnoses

Confidentiality & Information Sharing

The IM+CANS will become part of your medical record and may be:

- Reviewed by your assigned NEDFYS clinician or supervisor
- Shared with your Medicaid health plan (MCO) to authorize services
- Used for quality monitoring and treatment coordination, if needed
- Disclosed to other providers only with your consent, unless otherwise allowed by law (e.g., emergencies or mandated reporting)

All data is handled in compliance with HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

Consent and Signature

By signing below, I acknowledge that:

- I have received information about the IM+CANS process.
- I understand the purpose of this assessment and how the information will be used.
- I voluntarily consent to participate in the IM+CANS process.
- I understand that I may withdraw consent at any time by notifying my clinician.

Client's name:

Parent/Legal Guardian name (if Client is a minor):

Date:

Northeast DuPage Family & Youth Services Inc.

777 Army Trail Blvd.
Addison IL 60101-2787
6306937934

4. Informed Consent for Treatment - English

Client Full Name:

Client ID Number:

Welcome to NEDFYS

Thank you for choosing Northeast DuPage Family and Youth Services (NEDFYS). We are a community-based agency offering high-quality, accessible mental health and social services to individuals and families.

What Is Individual Counseling?

Individual counseling is a one-on-one service with a trained mental health professional (licensed or under licensed supervision). Services may include assessment, treatment planning, psychotherapy, care coordination, and crisis support.

Benefits

May include improved mental health, emotional well-being, and coping skills.

Risks

May include temporary emotional discomfort as sensitive topics are discussed. You are encouraged to ask questions at any time and to speak with your therapist if you experience distress during treatment.

Staff Qualifications

NEDFYS maintains high clinical standards. All services are provided by licensed clinicians or master's-level professionals working under the supervision of a licensed supervisor.

Client Rights

You have the right to:

- Actively participate in your treatment planning
- Refuse services or withdraw consent at any time
- Review and request copies of your clinical records
- Receive services free from discrimination or coercion
- File a grievance if you are dissatisfied with your care (see below)

Client Responsibilities

You are expected to:

- Attend all scheduled appointments or provide notice if you cannot attend
- Participate honestly and actively in treatment
- Notify your therapist of changes in symptoms, contact info, or health status
- Ask questions and share concerns about your care

Minor Consent

In Illinois, youth ages 12 and older may consent to mental health services without parent/guardian involvement for up to eight 90-minute sessions. Information shared in these sessions is confidential. Parents/guardians may request access to records, but access will be reviewed with the minor to determine if disclosure is appropriate (per the Illinois Mental Health and Developmental Disabilities Confidentiality Act).

HIPAA Privacy Notice

Northeast DuPage Family and Youth Services (NEDFYS) is required by federal and state law to protect the privacy of your health information. We maintain safeguards to ensure your records are secure and are only accessed or disclosed when permitted or required by law.

You have the right to:

- Receive a copy of your health records
- Request corrections to inaccurate or incomplete information
- Request limits on how your information is used or shared
- Receive a list of times your information has been shared for reasons other than treatment, payment, or operations
- File a complaint if you believe your rights have been violated

A full description of your rights is available in the NEDFYS Notice of Privacy Practices can be found at www.NEDFYS.org

Confidentiality and Legal Exceptions

Your information is confidential and will only be shared with your written consent unless:

- There is a risk of serious harm to yourself or others
- There is suspected abuse/neglect of a minor or vulnerable adult
- A court orders the release of records
- Disclosures are required for billing, supervision, or quality assurance

Records and Technology

NEDFYS uses a secure, cloud-based electronic health record (EHR) system. Records are accessible only to authorized clinical staff for treatment and supervision purposes. Your records may be accessed by new therapists as needed to ensure continuity of care.

Electronic Communication

NEDFYS offers the option to receive appointment reminders and general communication via text, email, or voicemail. These methods may not be fully secure and could be accessed by someone else with access to your devices or accounts. Please review and mark the methods of communication you authorize.:

- ☐ Text Messages
- ☐ Emails
- ☐ Voicemail Messages

We will never:

● Discuss detailed treatment information via text or email

● Use email or text for crises or urgent clinical needs

● Send your records without a separate signed Release of Information (ROI)

Medicaid-Specific Disclosures and Consent

If you are enrolled in Medicaid:

● Some services may require prior authorization by your Managed Care Organization (MCO)

● Your Protected Health Information (PHI) may be shared with Medicaid or your insurer to obtain payment or coordinate care

● You have the right to change providers at any time without penalty

● Interpreter services are available upon request at no cost

Financial Responsibility

You are responsible for understanding any potential fees or costs related to treatment. A separate Payment for Services Agreement will outline the specific terms. Services may be billed to Medicaid, private insurance, or provided at no cost, depending on your eligibility and funding source.

Grievance Process

If you are dissatisfied with your services or feel your rights have been violated, you may submit a grievance verbally or in writing to your therapist, NEDFYS Clinical Manager, or Compliance Officer. You may also contact your Medicaid health plan or the Illinois HFS Office of Inspector General.

Consent and Acknowledgement

By signing below, I confirm that:

● I have received and understand this Informed Consent for Treatment

● I have had the opportunity to ask questions

● I agree to participate in counseling services at NEDFYS

● I understand my rights, responsibilities, and privacy protections

Client's Name:

Parent/Legal Guardian's Name (if Client is a minor):

Date:

Northeast DuPage Family & Youth Services Inc.

777 Army Trail Blvd.
Addison IL 60101-2787
6306937934

7. Telehealth Informed Consent Form - English

Client Full Name:

Client ID Number:

Introduction to NEDFYS

Welcome to Northeast DuPage Family and Youth Services (NEDFYS). Our community-based agency provides high-quality, accessible mental health and social services. Services may be provided by licensed clinicians or by unlicensed staff under direct supervision.

Overview of Counseling & Telehealth Services

Individual counseling is a one-on-one process to help you manage mental health symptoms, address personal challenges, and improve well-being. Therapy may involve discussing distressing emotions or memories. You are encouraged to talk with your clinician if any part of your treatment becomes uncomfortable. Telehealth services allow you to engage in these sessions through secure video or phone technology. All NEDFYS Telehealth platforms are HIPAA-compliant.

Purpose and Scope of Telehealth

This form provides information about receiving services via telemental health and documents your consent. It includes risks, benefits, limitations, and emergency procedures related to Telehealth.

Client Rights and Responsibilities

You have the right to:

- Be treated with dignity and respect
- Actively participate in treatment planning
- Refuse any treatment or service
- Request access to your records

You are responsible for:

- Attending sessions regularly and on time
- Participating in your treatment
- Communicating any concerns with your therapist

Minor Consent (Age 12+)

Illinois law allows minors age 12 and older to consent to up to eight 90-minute sessions without parent/guardian permission. Records will not be shared without the minor’s consent unless required

by law or in an emergency.

Confidentiality and Limitations

NEDFYS protects your privacy following HIPAA and Illinois law. Your information is confidential except in the following cases:

- You pose a serious risk of harm to yourself or others
- Abuse or neglect of a child, elder, or vulnerable adult is suspected
- Your records are subpoenaed by a court

Technology & Session Expectations

- Sessions may occur via secure video or phone.
- No sessions may be recorded by either party.
- If you are more than 15 minutes late, the session may be canceled.
- If you appear to be under the influence of drugs or alcohol, the session will be terminated.
- You must be located in the state of Illinois during sessions unless pre-approved.

Telehealth Risks

Telehealth carries certain risks:

- Loss of connection or service interruption
- Potential for privacy breaches on unsecured devices or networks
- Limited ability to assess and intervene during crises

If technical issues arise:

- End and restart the session
- If not reconnected within 10 minutes, your therapist may call you and/or reschedule

Emergency Protocol

You agree to:

- Inform your clinician of your exact location at the start of each session
- Provide an emergency contact who can assist in case of a life-threatening emergency

Your therapist may contact emergency services or your emergency contact if you are in crisis.

Medical Records & Insurance

Your records are stored in a secure, cloud-based system. NEDFYS may disclose your Protected Health Information (PHI) to your insurance or Medicaid plan for billing purposes. Telehealth services are not recorded or released without proper authorization.

Consent and Acknowledgment

By signing below, I confirm:

- I understand the risks, benefits, and limitations of Telehealth

- I agree to follow the expectations outlined above
- I understand that I may withdraw my consent for Telehealth at any time
- I have received a copy of the NEDFYS HIPAA Privacy Notice

Client's Name:

Parent/Legal Guardian's Name (if Client is a minor):

Date: