SERVICE AGREEMENT / CONSENT FOR TREATMENT

Staff Practice

The Family Institute at Northwestern University is committed to strengthening and healing families from all walks of life through clinical service, education and research. The Family Institute offers a wide range of high-quality behavioral health care through our staff practice and sliding-fee-scale clinic.

Each location's hours are by appointment only. Please be aware that children under 12 years old cannot be left alone in waiting rooms. If your children are not participating in your session, please plan for their care.

TERMS OF AGREEMENT:

I. **SERVICES:** Services may include, but are not limited to, family, couple, individual and group therapy, as well as psychological testing, school consultation and other diagnostic services as recommended by the clinician. Services may also include the participation of parents/guardians and other significant family members, when appropriate. You or your clinician may suggest other kinds of services (non-direct) outside the scope of normal therapy that would be billable separately such as school visits, court appearances, phone consultations, writing or reviewing letters, reports, etc. Recommendations for treatment are first discussed with and approved by clients. Family Institute clinicians often work with multiple members of the family in different modalities (e.g., individual, couple or family therapy) and may consult with each other and share information in order to provide effective and coordinated care. When multiple clinicians are seeing different family members, the clinicians will secure your written consent before sharing information. Clinicians may share information with consultants or supervisors without your consent. Information provided separately by those participating in couple or family therapy is shared among members participating in that type of treatment at the therapist's discretion and with your written consent. Within our clinic, treatment length will be evaluated based on progress towards mutually agreed upon goals for therapy.

_____ _____ **(Client initials)**

II. **FEES & INSURANCE: Clients are expected to pay all fees and co-payments at the time of service**.

If clients become delinquent in payment of fees, The Family Institute may suspend or terminate treatment. Unpaid bills are turned over to collection after an appropriate attempt to collect.

Regarding Use of Insurance: Clients are responsible for contacting their insurance companies and understanding their insurance benefits prior to the first session. Not all therapists at The Family Institute are providers for all health insurance plans. Charges for services are the client's responsibility, including any services not covered by insurance, e.g., co-payments, deductibles, uncovered and ineligible services and all charges for services provided over the maximum allowable benefit for the year. We encourage clients to contact member services at their insurance company regarding their benefits prior to the first session so they are aware of what may or may not be covered.

SERVICE AGREEMENT / CONSENT FOR TREATMENT

Staff Practice

Please be aware that if we are not participating members of your health insurance company or your policy, there will be no coverage. For example, we do not have any agreement with United Behavioral Health, Magellan, ComPsych or Value Options, etc. Further, The Family Institute is NOT considered in-network for BCBS, and BCBS PPO rates do not apply.

Fees for Staff Therapy: Your fee was discussed with you at the time of scheduling your appointment.

_____ _____ **(Client initials)**

Fees for services (non-direct) outside the scope of normal therapy are billable separately at the clinician's regular fee in 10-minute increments. These may include school visits, court appearances, phone consultations, email correspondence, writing or reviewing letters, reports, etc. These charges are not typically reimbursed by insurance. It's recommended that you discuss with your therapist his/her approach to handling such charges, and the type of non-direct services that are likely to occur during the course of your work together.

_____ _____ **(Client initials)**

III. **APPOINTMENT CANCELLATION POLICY:** Charges apply for psychotherapy appointments canceled (or changed) with less than 24 hours' notice. Extenuating circumstances are considered when appropriate. However, insurance benefits do not cover cancellation charges**.**

_____ _____ **(Client initials)**

IV. **CONTACTING CLINICIANS:** Clients may leave confidential messages for their clinicians utilizing the Patient Portal or the voice mail system of The Family Institute at any time. The Family Institute does not provide after hours or emergency services. In case of emergencies, please call 9-1-1 or go to the emergency room.

_____ _____ **(Client initials)**

V. **QUALITY IMPROVEMENT / RESEARCH:** I understand that The Family Institute's mission includes research. I agree that The Family Institute may use my de-identified (anonymous) questionnaire data for quality improvement/quality control and research purposes in accordance with the law. I may be contacted for potential recruitment into a specific research study, at which time I may choose to enroll or decline to participate. No identifiable information will be used without my explicit consent. There will be no adverse consequence to declining to participate in any proposed research.

VI. **ELECTRONICALLY FACILIATED PSYCHOTHERAPY / TELETHERAPY:** At some point during your care you may choose to receive electronically facilitated services from The Family Institute. To protect

SERVICE AGREEMENT / CONSENT FOR TREATMENT
Staff Practice

your privacy in accordance with the federal requirement defined in the Health Information Privacy and Affordability Act (HIPAA), these services will be provided via a video platform that is HIPAA compliant. As with all electronic forms of communication, there are risks to privacy that do not exist in face to face therapy that cannot be completely removed despite following best privacy practices.

While some insurance plans are reimbursing for teletherapy, at the present time the coverage for electronically mediated mental health treatment services is not guaranteed. Therefore, if your plan does not cover teletherapy and you choose to use these services, you agree to be wholly responsible for the cost of these services, which will be billed at the usual rate for your therapist's time. You agree to be responsible for providing the computer and/or necessary telecommunications equipment and internet access if you choose to utilize teletherapy sessions, as well as, arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for these sessions.

VII. **COMMUNICATIONS:** Periodically, The Family Institute sends news and updates on its various programs and activities. You will receive eNewsletters, helpful Tips of the Month, donor stewardship materials and invitations from The Family Institute. If at any time you wish to stop receiving these communications, please send written communication to the Privacy Officer of The Family Institute, 618 Library Place, Evanston, IL 60201 or click "Unsubscribe" in the footer of any received email.

VIII. **AUDIO AND VIDEO RECORDING:** Staff clinicians may wish to record sessions. **Audio and video recordings may be reviewed by the clinician and/or their supervisor to assure high quality of care. Audio and video recordings are considered protected health information and will not be used or shown outside of clinician / supervisor review without the client's written consent. Once they have been reviewed, they are deleted.**

I/We grant permission to The Family Institute to make video and/or audio tape recordings with me/us and my/our family for *supervision or clinical consultation*. I/We will always be notified when tapes are being made, and I/we may refuse video and/or audio taping of interviews at any time.

_____ _____ (Client initials)

□ Client does not consent to recording

IX. **FOID MENTAL HEALTH REPORTING REQUIREMENT:** As per Illinois Firearm Concealed Carry Act, all physicians, clinical psychologists and qualified examiners are required to notify the Department of Human Services (DHS) within 24 hours of determining a person to be a Clear and Present Danger to themselves or others, Developmentally Disabled or Intellectually Disabled, regardless of the provider's practice, the person's age or any other diagnosis of this person.

_____ _____ (Client initials)

SERVICE AGREEMENT / CONSENT FOR TREATMENT

Staff Practice

X. **MANDATED REPORTING:** All clinical service providers at The Family Institute are mandated reporters. This obligates them to comply with the Abused and Neglected Child Report Act that states that any worker "having reasonable cause to believe a child known to them in their professional capacity may be an abused or neglected child shall immediately report or cause a report to be made to the Department." All mandated reporters in the State of Illinois are also required to report suspected or reported "abuse, neglect or financial exploitation" of individuals over the age of 60 years to the Department of Aging.

_____ _____ **(Client initials)**

XI. **NOTICY OF PRIVACY PRACTICES:** By signing, you acknowledge that you have received the Notice of Privacy Practices of The Family Institute at Northwestern University. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

_____ _____ **(Client initials)**

Client Consent to Terms of Agreement:

I/We, the undersigned, understand this Service Agreement and apply for services at The Family Institute in accordance with this agreement. A signature is required from the parent(s) or guardian(s) who have legal responsibility for medical decisions for children in treatment.

I/We understand that I/we have the right to revoke this consent at any time. This revocation must be in writing to The Family Institute.

Participants in Treatment:

Printed Name	Signature	Email Address
Printed Name	Signature	Email Address
Printed Name	Signature	Email Address
Printed Name	Signature	Email Address
Printed Name	Signature	Email Address

SERVICE AGREEMENT / CONSENT FOR TREATMENT

Staff Practice

Printed Name	Signature	Email Address

As guarantor, I am accepting financial responsibility for services received at The Family Institute. I am also responsible for notifying The Family Institute Billing Department if my status as guarantor has changed or if financial responsibility for treatment is a shared responsibility. If I do not inform The Family Institute Billing Department, I remain liable for the charges.

Guarantor's Name	Signature	Email Address