# 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 working with multiple members of the family in different modalities (e.g., individual, couple or family therapy) will, with your consent, consult with each other and share information in order to provide effective and coordinated care. Information provided by those participating in couple or family therapy is shared among members participating in that type of treatment. Within our clinic, treatment length will be evaluated based on progress towards mutually agreed upon goals for therapy.

_____ _____ (Client initials)

II. **ELECTRONICALLY FACILIATED PSYCHOTHERAPY:** Your clinician may provide one or more forms of electronically facilitated therapy, including teletherapy or a therapeutically oriented email exchange. At this time, insurance companies do not provide coverage for these services and clients are expected to pay the clinician's regular fee. Before electronically mediated psychotherapy can be initiated, your clinician will conduct an in-person assessment and review limits, if any, to ensure your confidentiality.

_____ _____ (Client initials)

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

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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.

_____ _____ (Client initials)

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 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, are the client's responsibility. We encourage clients to contact member services regarding their benefits prior to the first session so they are aware of what may or may not be covered.

Please be aware that if your mental health benefits are covered through another carrier, such as United Behavioral Health, Magellan, ComPsych or Value Options, etc., The Family Institute is NOT considered in-network, and BCBS PPO rates do not apply.

Fees for Staff Therapy: Your fee will be $_____ for the initial session/ assessment; and $_____ per session thereafter.

_____ _____ (Client initials)

Fees for services (non-direct) outside the scope of normal therapy are billable separately at the clinician's regular fee. These may include school visits, court appearances, phone consultations, 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)

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

_____ _____ (Client initials)

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V. CONTACTING CLINICIANS: Clients may leave confidential messages for their clinicians on the voice mail system of The Family Institute at any time. The Family Institute does not provide after hours or emergency services. For after hour communication with your clinician, please leave an email or voicemail message. In case of emergencies, please call 9-1-1 or go to the emergency room.

_____ _____ (Client initials)

VI. 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.

VII. AUDIO AND VIDEO RECORDING: Staff clinicians may wish to record sessions. **Audio and video recordings are considered protected health information and will not be released or shown without 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

I/We grant permission to The Family Institute to make video and/or audio tape recordings with me/us and my/our family for *instruction and teaching*. 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

VIII. 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

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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)

IX. 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)

X. 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 |

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| Printed Name | Signature | Email Address |
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| Printed Name | Signature | Email Address |
| Printed Name | Signature | Email Address |
| 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 Initials)**

| Guarantor's Name | Signature | Email Address |
|---|---|---|

| Family Institute Clinician Name | Signature | Date |
|---|---|---|

THE FAMILY INSTITUTE
at Northwestern University

## CONSENT FOR RELEASE OF INFORMATION
## THE FAMILY INSTITUTE

Client Name _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

The undersigned authorizes The Family Institute (TFI) to: [Circle the option(s) that is(are) appropriate] release to obtain from

Name _____ Relationship _____

Address _____ Phone Number _____

the following records and information concerning client, for the period of _____(m/d/y) to _____(m/d/y).
Initial the category(ies) of information that is (are) appropriate.

_____ Discharge Summary _____Treatment Notes _____Treatment Plans

_____ Social Assessment _____Psychiatric Evaluation _____Correspondence

_____ Psychological Evaluation _____Telephone Consultation _____Progress Reports

_____ HIV related information (client must sign this separately) _____

_____ Drug and Alcohol use, evaluation or treatment information (client must sign this separately)_____

_____ Other (specify):_____

I also authorize re-disclosure of records from the following individuals and/or agencies: _____

This information shall be used for the following purpose (s):

_____ follow-up care_____placement_____treatment planning_____other (specify) _____

_____

This consent expires on_____. If no date is specified, the consent shall be valid only on the date received for this particular consent for release of information. I understand that I may revoke this consent in writing at any time but that such revocation is effective only with respect to any future requests for disclosure and does not retroactively apply to any disclosure made by _____ in reliance on this release prior to the date it receives a revocation from me. I also understand that any written revocation must be accompanied by the signature of a witness.

I understand that the consequence of my refusal to consent, if any, would be: _____

Date _____ Signature of client (required if client is 12 years of age or older) _____

Date _____ Signature of parent or guardian (required if client is under 18 years of age or has been adjudicated incompetent) _____

Date _____ Witness _____

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, no person or agency to whom any of this information is disclosed may re-disclose such information unless the person who consented to this disclosure specifically consents to such re-disclosures.

Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization for such re-disclosure.

Effective August 1, 2005, The Family Institute requires a copying fee for anyone requesting records (i.e., patients, attorneys, insurance carrier) in the amount of $20 for up to 20 pages of material, plus an additional $0.10 per page beyond 20. Waivers of this fee will be considered upon written request to the medical records department.