SERVICE AGREEMENT / CONSENT FOR TREATMENT

Bette D. Harris Family and Child Clinic

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 may be billable separately such as 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.

II. **SUPERVISION & CLINIC CLINICIANS:** Service provided in the Bette D. Harris Family and Child Clinic is provided by clinicians who are receiving advanced training as psychotherapists and are supervised by at least one senior clinician on a weekly basis in an individual and group setting. Clients have a right to know the identity and credentials of the senior supervising clinician(s) involved with their care. It is expected that your clinician will set goals with you for treatment and work on goals established in an assessment. If you are still in treatment at the end of your clinician's training at The Family Institute (your clinician will notify you of their expected end date), your clinician will review the status of these goals with you and consider whether further treatment is indicated and if so, where it would be best for that to take place and with whom.

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

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IV. APPOINTMENT CANCELLATION POLICY: Charges apply for psychotherapy appointments canceled (or changed) with less than 24 hours' notice. Extenuating circumstances are considered when appropriate.

_____ _____ (Client initials)

V. CONTACTING CLINICIANS: Clients may leave confidential messages for their clinicians via 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.

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. QUALITY IMPROVEMENT AND RESEARCH: I understand that The Family Institute's mission includes research. I agree that The Family Institute may use my de-identified 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.

VIII. AUDIO AND VIDEO RECORDING: For the Bette D. Harris Family and Child Clinic, clinicians-in-training routinely record sessions by audio and/or video in order to review their work with supervisors. **Audio and video recordings are considered protected health information and will not be released or shown without consent.**

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

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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

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.

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.

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)

XII. ELECTRONICALLY FACILIATED PSYCHOTHERAPY: At some point during your care you may choose to receive electronically facilitated services from The Family Institute. To protect 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, such as third-party eavesdropping or intrusion on sessions, that do not exist in face to face therapy that cannot be completely removed despite following best privacy practices. You agree to be responsible for providing the computer and/or necessary telecommunications equipment and internet access if you choose to utilize

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teletherapy session, as well as, arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for these sessions.

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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
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