THE FAMILY INSTITUTE
at Northwestern University

SERVICE AGREEMENT/CONSENT FOR TREATMENT

Welcome to The Family Institute at Northwestern University

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 Institute offers a wide range of high quality mental health counseling through our staff practice and sliding-fee-scale clinic.

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

TERMS OF AGREEMENT:

I. **SERVICES:** May include but are not limited to family, couple, individual, and group therapy, as well as psychological testing, school consultation, psychiatric consultation, evaluation and treatment as well as 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 the clients. Family Institute clinicians working with multiple members of the family in different modalities (eg. Individual, couple or family therapy) will 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's Initials)**

II. **ELECTRONICALLY MEDIATED PSYCHOTHERAPY:** Because of the nature of email, real-time chat, phone therapy, and video-conferencing the Institute cannot guarantee the privacy of these communications. Therefore clients acknowledge the potential risk to confidentiality inherent in the use of these technologies. Additionally, 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. _____ **(Client's Initials)**

III. **SUPERVISION & CLINIC CLINICIANS:** Services provided in The Bette D. Harris Family and Child Clinic is rendered by clinicians who are receiving advanced training as psychotherapists who are supervised by at least one senior staff person on a weekly basis. Clients have a right to know the identity and credentials of the supervisor(s) involved with their case.
Clinicians in training are typically available for about one to one and one-half years. It is expected that your clinician will set goals with you for the treatment or work on goals that were set in an assessment. At the end of your clinician's training at The Family Institute, he or she 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. _____ **(Client's Initials)**

IV. **FEES & INSURANCE:** Clients are expected to pay all fees and co-payments at the time of service. If clients choose to submit bills to insurance, clients are responsible for contacting their insurance companies and understanding their insurance benefits. When possible, charges will be submitted electronically. Charges for services not covered by insurance are the clients' responsibility. If insurance changes during the course of therapy, clients should notify their clinician immediately to ensure continued coverage of services. Not all clinicians at The Family Institute accept all insurance plans. No health insurance is accepted in the Bette D. Harris Family and Child Clinic. Clinicians will review their fees with clients as well as insurance coverage at the outset of therapy. If clients become delinquent in payment of fees, The Family Institute may terminate therapy. Unpaid bills are turned over to collection after an appropriate attempt to collect. Your fee will be $_____ for the initial consultation and $_____ per 30 - 60 minute session. For psychiatric services fees vary depending on the nature of services provided. For non-direct services described in the *Services* section above, clients are billed in 10 min intervals for services longer than 10 min at clinician's regular fee. For psychological and neuropsychological assessments, your fee will be $_____ due at the first session and $_____ due at the next session. _____ **(Client's Initials)**

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

VI. **CONTACTING CLINICIANS:** Clients may leave confidential messages for their clinicians on the voice mail system of The Institute at any time. In emergencies, clients can have the operator contact their clinician or the on-call clinician by calling (847) 733-4300, ext. 0. _____ **(Client's Initials)**

VII. **COMMUNICATIONS:** Periodically, The Family Institute sends news and updates on its various programs and activities. By checking this box, you will receive eNewsletters, Tips of the Month, donor stewardship materials and invitations from The Family Institute. I do not wish to receive helpful information from the Family Institute. _____ **(Client's Initials)**

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. Staff clinicians may also wish to record sessions.

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's 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's Initials)** Client does not consent to recording

IX. **FOID MENTAL HEALTH REPORTING REQUIREMENT:** As per the Illinois Firearm Concealed and 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 the person.
_____ **(Client's Initials)**

X. **NOTICE 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's Initials)**

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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, as well as any child 12 years old or older.

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.

As guarantor, I am accepting financial responsibility for services received at The Family Institute. **Date of Form**_____

Guarantor's 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
Family Institute Representative Name	Signature	Date