SERVICE AGREEMENT/CONSENT FOR TREATMENT

Welcome to Lighthouse Counseling Center

Lighthouse Counseling Center (LCC) is committed to strengthening and healing families from all walks of life through clinical service, education and research. LCC 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, 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 the clients. Lighthouse 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, phone therapy, and video-conferencing, the counseling center 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 at LCC may be rendered by counselors-in-training who are receiving an advanced masters-level education. They are supervised by at least one senior staff member who is a Licensed Clinical Professional Counselor (LCPC). Clients have a right to know the identity and credentials of the supervisor(s) involved with their case. 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 Lighthouse Counseling Center, 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. A change in insurance while in therapy may result in claim denials.
Some insurance plans may use third party administrators to pre-authorize their mental health benefits. LCC will endeavor to contact your insurance provider prior to your treatment to determine if pre-authorization is required. Please work directly with the billing department to ensure that all authorizations are acquired at the appropriate times in order to maximize your benefits. If services are performed without authorization, all uncovered services or services covered at a lower rate will be the client's responsibility. Please be aware that if your mental health benefits are covered through another carrier, such as United

Behavioral Health, Magellan, ComPsych or Value Options, LCC is not considered in network, and PPO rates do not apply. Outsourced coverage cannot be submitted electronically, and you will be expected to pay the full fee at the time of service. 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, LCC may terminate therapy. Unpaid bills are turned over to collection after an appropriate attempt to collect.

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 by calling their direct phone numbers. In emergencies, clients call 911.______ **(Client's Initials)**

VII. **COMMUNICATIONS:** Periodically, LCC 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 LCC. ☐ I do not wish to receive helpful information from the LCC. ______ **(Client's Initials)**

VIII. **AUDIO AND VIDEO RECORDING:** At LCC, counselors-in-training routinely record sessions by audio and/or video in order to review their work with their practicum/internship, as well as, university supervisors. Staff clinicians may also wish to record sessions. ☐ I/We grantt permission to Lighthouse Counseling Center 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.

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 Lighthouse Counseling Center. 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)**

Client Consent to Terms of Agreement:

I/We, the undersigned, understand this Service Agreement and apply for services at Lighthouse Counseling Center 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 LCC.

As guarantor, I am accepting financial responsibility for services received at Lighthouse Counseling. **Date of Form ____________**

Name:____ Signature:____

Lighthouse Representative:______________________________ Signature:____