Heartland Family Service

Professional Counseling

CLIENT SERVICE AGREEMENT

Iowa Gambling Distance Treatment Program

CONSENT TO SERVICE:
By signing below, I authorize Heartland Family Service (HFS), its Counselors/Therapists and other professional staff to provide services to me and/or my minor child. I acknowledge that HFS will provide the services that they believe are most appropriate, in their professional judgment, and that nobody has guaranteed any particular results from these services.

ASSIGNMENT OF PAYOR OR INSURANCE BENEFITS:
I assign to HFS all benefits, which are available for the services rendered at HFS, under any insurance policy or payment program I am eligible for (specify): _____ and I authorize payment of any benefits directly to HFS. I authorize HFS to bill the insurer or payment program, to collect payment for its services and receipt for any payment. At any time there is a credit balance in my name due to an overpayment to HFS**,** I authorize the credit balance be applied to any other account owed by me or any member of my family.

AUTHORIZATION FOR RELEASE OF INFORMATION:
I authorize HFS to give and receive information and records about me or my family members, including Protected Health Information such as (but not limited to) professional opinions, reports of tests and examinations, treatment summaries, diagnosis and prognosis to my insurer or payment program (insurance company, government agency or self-insured employer) in connection with the billing review and payment process. I understand that I will be provided with a Notice of Privacy Practices, which includes a description of the agency's privacy protections and limitations, as well as my rights regarding privacy.

FINANCIAL COMMITMENT (Please initial)
_____ I understand I am responsible to pay all the fees charged by HFS for the services rendered to me or my family at the time of services. I agree to pay $ _____ for the initial evaluation, $ _____ per individual/family session and $ _____ per group session. I am also responsible for past balances in the amount of $_____.
_____I understand that payment is expected at time of service. If I am unable to pay, I will request a payment plan..
_____I understand that refusal to pay agreed upon fees may result in termination of services.
_____I understand that in order for my Discharge Summary to be released, my bill will need to be paid IN FULL.
_____I understand it is my responsibility to provide changes in either my insurance benefits or income status.

FEE ADJUSTMENT:
If at any time you are unable to pay your fee, please speak with a HFS staff person who can provide you with a Fee Adjustment Application and Budget Form. If this fee adjustment is approved, the new fee and its timeframes will take the place of the fee noted above.

INFORMED CONSENT FOR DISTANCE TREATMENT AND DIGITAL COMMUNICATION
I consent to participate in the **Iowa Gambling Distance Treatment Program**. I understand that in this program, communication with my therapist may include:
☐sending and receiving of secure mail communications through the Distance Treatment Site
☐text message
☐telephone communication regarding my treatment:
☐some "in person" or "face to face" meetings with my therapist.
I understand that email, text, or distance treatment site must not be used for urgent or emergency situations and that I must use the telephone including emergency/on call access in an emergency where immediate response is needed.

Risks, Benefits of, and Alternatives to Web Site, Email or Text Use

Risks:

- Messages may be sent but not received or delivered to wrong party
- Confidentiality may be breached by phone or email being intercepted on either the sending or receiving side, or in transit.

Benefits:

- Access to send messages at any time
- Opportunity to compose messages and responses thoughtfully
- Record of communications for ongoing reference

Alternatives:

The alternative to digital communication includes personal discussion in sessions, and telephone calls.

Agreements

Client Rights and Responsibilities:

- I agree to keep my scheduled appointment times (phone or in person) and to inform my therapist at least 24 hours in advance if I need to cancel.
- I will be free of the influence of drugs and alcohol during sessions or calls.
- I will complete assignments as agreed on with my therapist; and submit my own work.
- I will protect the privacy of my login information.
- I will protect the privacy of other clients involved in this program.
- Distance treatment is focused on establishing and reaching the goals I want from treatment. I understand that my continuation and discharge from the program will be individualized and discussed with my therapist
- I understand that I am responsible for safeguarding my sent and received email, text, phone or video. communications from access by others in my home or work environment; or from shared or public computers if applicable. I understand that a separate password protected account is preferable.
- Through my email carrier, I may request "return receipt" to acknowledge that the message has been received.
- I understand that Email from my work accounts is NOT CONFIDENTIAL and should not be used for any sensitive personal or treatment information.
- I understand that Email is not to be used for any emergency or urgent communications. I agree to follow established emergency contact procedures.
- I understand that my digital communications with my therapist will be kept as part of my treatment record.
- My therapist and I may establish guidelines as necessary regarding the volume and frequency of digital communication which support effective treatment.
- I may revoke my consent for email or other digital communication at any time by informing my therapist.
- My therapist may opt to discontinue email or other digital communication if it is inappropriate or unsafe to continue it.
- I understand that Heartland Family Service has established, and adheres to, confidentiality practices for all client information including communications by phone, email, text, and distance treatment; as well as safeguards on the privacy of emails received by employees.
- I understand that Heartland Family Service assesses the security of video or other distance treatment sites that it utilizes, but does not directly manage these sites; and that it is unlikely but possible that security could be breached.
- I understand that my phone number, email address and any other private information will not be directly or intentionally disclosed by Heartland Family Service to anyone else without my consent, in accordance with agency policies.

REVOCATION:

I understand that I can revoke this agreement at any time, except 1) the revocation may not apply to any services already rendered, or any disclosures already made, and 2) once services are rendered, I cannot revoke my financial agreement, my assignment of benefits, or my authorization to release information with respect to those services.

A photocopy of this Agreement shall be considered as valid as the original. By signing below, I certify that I have read the foregoing or it has been read to me, that I understand it completely, and that this Agreement is given knowingly and voluntarily.

_____	_____	_____
Client Name (please print)	Client Signature	Date
_____	_____	_____
Responsible Party (please print)	Responsible Party Signature	Date
_____	_____	_____
Insured Signature Date	Witness	Date