

## **Informed Consent Form**

Welcome to the XX Psychological Clinic. This form will provide information about 1) our professional services and special conditions related to services at a training clinic, 2) summary information about the Health Insurance Portability and Accountability Act (HIPAA), confidentiality, and about your rights and responsibilities as a client, and 3) our Clinic business practices.

This document represents an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding, except in the following cases: a) the Clinic has already taken action in reliance on this agreement, b) the Clinic has legal obligations imposed on it by a court of jurisdiction, or c) if you have not satisfied financial obligations you have incurred. Your signature at the bottom indicates that you understand the information and freely consent to the services described herein. It is important that you read this form carefully and ask any questions you might have.

### **Purpose and Mission of the XX Psychological Clinic**

At the XX Psychological Clinic, services are rendered by trainees who are graduate students in the Clinical Psychology doctoral program at XX. All psychological trainees are supervised by Ph.D. psychologists on the clinical faculty at XX or licensed psychologists in the community. As a client of the Clinic, your clinician will introduce him or herself to you and provide the name of his or her supervisor.

In addition to training, we also have a service mission. The XX Psychological Clinic is dedicated to providing quality psychological services to the Mid-Michigan community at low cost. You have been invited to meet with a clinician for initial consultation and evaluation sessions aimed to determine whether the services offered by the Psychological Clinic are a good match for your needs. Upon completion of this consultation and evaluation, you and your clinician will be better able to assess whether the Psychological Clinic is the right place for you. Options considered include continued treatment within the Clinic – either with the clinician who conducted your consultation or another clinician – or referral to another agency within the community.

In consenting to participate in initial evaluative sessions, you are indicating your understanding that you are not being offered therapy at this time, but rather assistance in identifying the best treatment for your situation. The evaluation process does carry some risks of psychological distress. It is not uncommon, for example, to experience feelings of sadness, anger, anxiety, or guilt while describing what prompted you to seek treatment. These feelings may be a natural and normal part of determining what form of help will be most useful to you, but they can also be unexpected and confusing. You are encouraged to discuss with your clinician any feelings or concerns that arise during your meeting.

### **Health Insurance Portability and Accountability Act (HIPAA)**

A federal law, HIPAA, provides privacy protections for medical records and rights for clients about the use and disclosure of your Protected Health Information (PHI). HIPAA requires that the Clinic provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. The Notice of Privacy Practices, which is included in this package, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that the Clinic has provided you with this information.

### **Professional Records and Client Rights**

The laws and standards of the psychology profession require that the Clinic keep Protected Health Information (PHI) about you in your clinical record. Generally, you may examine and/or receive a copy of your clinical record, if you request it in writing. Because these are professional records, you may wish to initially review them in the presence of your clinician, or have them forwarded to another mental health professional so you can discuss their contents. You may also decide it is more appropriate for us to prepare a written summary of your records for you.

HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of protected health information. These rights include requesting that the Clinic amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures were sent; having any complaints you make about the Clinic policies and procedures recorded in your records; and the right to a paper copy of this agreement, the attached Notice form, and our privacy policies and procedures. Your clinician will be happy to discuss any of these rights with you.

### **Confidentiality**

Michigan law protects the privacy of communications between a client and a psychologist. Every effort will be made to keep your evaluation and treatment strictly confidential. In most situations, the Clinic will only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements.

In the following situations, no authorization is required:

- a) Aspects of clinical information may be shared within the XX Psychological Clinic for educational and therapeutic purposes. All staff members are legally and ethically bound to keep this information confidential.
- b) Information is also shared for administrative purposes such as appointment scheduling, billing and quality assurance. All staff members have been given training about protecting your privacy.
- c) On occasion, the Clinic may find it helpful to consult with an outside health or mental health professional. During such a consultation, identifying information is disguised to protect your confidentiality. The other professional is legally bound to keep the information confidential. All consultations are noted in the client's Clinic record.
- d) Disclosures required to collect overdue fees.

### **Limits of Confidentiality**

There are situations where the Clinic may be required or permitted to disclose information without your authorization. These situations are unusual in this clinic. These include:

- a) If the Clinic has knowledge, evidence, or reasonable concern regarding the abuse or neglect of a child, elderly person, or disabled person, it is required to file a report with the appropriate agency, usually the Department of Health and Welfare. Once such a report is filed, we may be required to provide additional information.
- b) If a client communicates an explicit threat of serious physical harm to a clearly identifiable victim or victims, and has the apparent intent and ability to carry out such a threat, the Clinic may be required to take protective actions. These actions may include notifying the potential victim, and contacting the police, and/or seeking hospitalization for the client.

c) If we believe that there is high risk that a client will physically harm himself or herself, we will also take protective actions. (See Care during Crisis Situations).

d) Although courts have recognized a therapist-patient privilege, there may be circumstances in which a court would order the Clinic to disclose personal health or treatment information. We also may be required to provide information about court ordered evaluations or treatments. If you are involved in, or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order the Clinic to disclose information.

e) The Clinic is required to provide information requested by a legal guardian of a minor child.

f) If a government agency is requesting information for health oversight activities or to prevent terrorism (Patriot Act), the Clinic may be required to provide it.

g) If a client files a worker's compensation case, the Clinic may be required, upon appropriate request, to provide all clinical information relevant to or bearing upon the injury for which the claim was filed.

h) If a client files a complaint or lawsuit against the Clinic or professional staff, the Clinic may disclose relevant information regarding the client in order to defend itself.

If any of these situations were to arise, the Clinic would make every effort to fully discuss it with you before taking action, and would limit disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions you have with us now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

### **After Hours Contact/Emergencies**

The operating hours of the Psychological Clinic are Monday through Thursday 8:15 a.m. to 9:00 p.m., Friday 8:15 a.m. to 5:00 p.m. and Saturday 10:00 a.m. to 2:00 p.m. The phone is answered by the receptionist or by voicemail during open hours, and by an answering service after hours.

The Psychological Clinic is not equipped to offer treatment on an emergency, walk-in, or crisis-intervention basis. **For this reason, it is important to be aware of the general support services that are available to you in your community. In the event of a crisis, you can: a) Go to the emergency room of the nearest hospital for an evaluation or b) Call Emergency Services at XX or XX, a 24-hour crisis intervention service or c) Call 911.**

### **Minors and Parents**

Please be informed that any person with legal rights pertaining to a child (e.g. legal guardian) may have the legal right to terminate a child's treatment. As stated earlier, the XX Psychological Clinic will honor requests for information by a legal guardian of a minor child.

Clients under 18 years of age who are not emancipated from their parents, should be aware that the law allows parents to examine their clinical record. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is Clinic policy to ask parents to respect the privacy of their child's treatment. Typically, with parents' agreement, a clinician provides only general information about the progress of a child's treatment. With teenagers, more

detailed disclosures are typically discussed beforehand with the teenager in order to minimize his/her objections and concerns, unless the Clinic feels it is a crisis situation, including personal risk or physical danger to the minor.

In the context of family therapy, should family members be seen individually, material discussed may be shared with all family members when your clinician believes it to be in everyone's best interest. In this circumstance, your clinician would encourage the individual to initiate sharing the information, but he/she reserves the right to bring up the information if he/she thinks it is useful for the whole family.

### **Taping**

For educational purposes, therapy sessions may be audio and/or video recorded. The clinician will listen to the tapes and discuss your case with his/her supervisor and, in some cases, a small practicum team. By signing this form, you are giving us permission to audiotape your therapy sessions.

### **Research**

For research purposes, information we gather about your treatment may be anonymously combined with other data we gather in the Clinic. When we do this, your name and other identifying information is removed so that your confidentiality is protected. Aggregated clinical data of this kind is useful to research scientists who are studying the clinical process. We will not use this kind of research information about your treatment here without your explicit consent.

### **Fees**

Clients agree to pay the fees established during their consultation. This fee is a sliding scale fee based on your total annual household income before taxes and the number of people supported by that income. Payment for therapy sessions is due at the time of each appointment. Please note that we do not accept insurance, and you should be aware that many insurance companies do not reimburse for psychotherapy services provided by clinicians in training.

### **Cancellation and Missed Appointments**

Clinic policy requires payment for missed therapy sessions. If you cannot attend a scheduled appointment, we ask that you call to cancel the appointment at least 24 hours in advance. Missed appointments for reason other than emergencies will be billed at your normal hourly fee. You will be expected to pay this fee at the beginning of your next scheduled session.

### **Contacting your Clinician and Vice Versa**

During the time the Clinic is open, you may leave a message on the answering machine or with our receptionist at XX. It is important to be aware that the Clinic receptionist does not keep the clinicians' time schedules and generally cannot answer questions regarding clinician availability. It may take your clinician 24-48 hours to return your call.

Your clinician and administrative personnel from the Clinic may need to use your name, address, phone number, and your clinical record to contact you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. If you would prefer not to be contacted by the Clinic by phone or if you would prefer that we do not leave a message on your answering machine, please inform your clinician of this.

### **Informed Consent to Receive Evaluation and/or Treatment Services**

Your signature below indicates that you have read this agreement, that these matters have been explained to you, and you fully and freely give consent to receive evaluation and/or treatment services here.

\_\_\_\_\_  
Name of Client(s) *please print*

\_\_\_\_\_  
Signature of Client(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative of Minor Child (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed by

\_\_\_\_\_  
Date

**Informed Consent for Aggregated/Anonymous Data to be Used for Research Purposes**

Your signature below indicates that you have read this agreement, that these matters have been explained to you and you fully and freely give consent for anonymous data from your treatment to be used for research purposes.

\_\_\_\_\_  
Name of Client(s) *please print*

\_\_\_\_\_  
Signature of Client(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative of Minor Child (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed by

\_\_\_\_\_  
Date