

CONSENT FOR SERVICES – THERAPY

Revised July 2020

I have read and understand this “Consent for Services” form and have been given an opportunity to ask questions about my contact with the TAMU Psychology Clinic.

1. I give my permission for (*circle one or both and write full name*)

(a) me, _____,

(b) my child, _____, as his/her parent or legal guardian,

to receive psychological services through the TAMU Psychology Clinic. I understand that psychological services involve a joint effort between Therapist and client, the results of which cannot be guaranteed. For example, progress in therapy or an evaluation depends on many factors including motivation, effort, and other life circumstances such as my interactions with family, friends, and other associates.

2. I understand that my Therapist (who is a clinical psychology graduate student) works under the supervision of a Faculty Supervisor. I understand that contact between me and my Evaluator/Therapist may be observed or audio/video recorded (with my knowledge) for review by the Faculty Supervisor or graduate students in training. In addition, I understand due to the nature of this facility as a clinical psychology training clinic, my case may be transferred to another Therapist. Such a transfer will be discussed with me in advance.

3. If it is determined that the Clinic is not capable of meeting my specific needs, I will be referred to community mental health practitioners or agencies.

4. I have been given the opportunity to discuss the use of audio/video recordings, which are for training purposes of the Therapist only, and are not stored as part of my medical record. They are deleted on a regular basis.

5. I understand my rights of confidentiality and the legal and ethical limits of confidentiality described in the “Notice of Policies and Practices to Protect Privacy of Your Health Information” statement. Specifically, I understand that my Therapist is required to disclose confidential information without my consent in certain circumstances that include, but are not limited to, the following:

(a) if I am evaluated to be a danger to myself or others;

(b) if I am a minor, elderly, or disabled person and he/she believes I am the victim of abuse or if I divulge information about such abuse;

(c) if I file suit for breach of duty; and

d) if a court order, other legal proceedings, or statute requires disclosure.

6. In the following additional situations, no authorization to release client information is required:
- (a) Clinical information about my case may be shared among clinical psychology practicum students and faculty for educational and training purposes. If students or faculty present case information at professional conferences or clinical program seminars, the information will be de-identified such that it is not possible to link the information to me or my family.
 - (b) Personal information is used for Clinic administrative purposes such as scheduling, billing, and continuous quality improvement. Clinic files may also be available to clinical doctoral program accreditation reviewers or auditors or other regulatory agencies. These records review situations will be conducted in a manner that protects the confidentiality of my records.
 - (c) Data contained in my file are available for archival office studies (i.e., reviews of records to describe Clinic referrals, outcomes, and trends) as long as my identity cannot be linked to the data used.
7. I understand the Clinic policies regarding fees, billing, and missed appointments and agree to the terms of payment. Specifically, I understand I am responsible for payment of services at the rate of:
- \$_____ per 20- to 30-minute session and \$_____ per 50- to 60-minute session
8. I understand that a “failure to cancel” fee (equal to the rate per hour) will be charged to me if I fail to cancel a scheduled appointment at least TWO (2) hours in advance. I also understand that I may be charged for extensive telephone consultation at the session rate, adjusted for actual time spent.
9. I understand that the first few appointments will be dedicated to gathering evaluation information to determine my specific treatment needs. The goal of these first few sessions will be to clarify if the Clinic is capable of serving my specific needs and, if so, to develop a treatment plan with me. If it is determined that the Clinic is not capable of meeting my specific needs, I will be referred to community mental health practitioners or agencies. My Evaluator may not necessarily be the same person who serves as my Therapist.
10. I understand that, in accordance with House Bill 910, Texas Senate Bill 11, and TAMU Campus Carry Policy, firearms are prohibited in the Clinic.
11. I understand that I may be asked to participate in research activities conducted in the Clinic, but will not be included in a specific research project without my written consent. All research projects conducted in the Clinic must be approved by University and Departmental authorities and are conducted in a manner that protects the privacy and safety of participants. Participation in research activities is voluntary and is not a condition of receiving services in the Clinic.

Client’s Signature	Date	Guardian’s Signature	Date
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Therapist’s Signature	Date	Faculty Supervisor's Signature	Date
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