CARLS CENTER FOR
CLINICAL CARE AND EDUCATION
PSYCHOLOGICAL
TRAINING AND
CONSULTATION CENTER
CENTRAL MICHIGAN UNIVERSITY

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Informed Consent

Client Name: _____ Date of Birth: ___/___/_____ MRN: _____

Welcome to the Psychological Training and Consultation Center (PTCC) at Central Michigan University! This consent document contains important information about our psychological services. Please read each section carefully and ask any questions you may have. You will initial each section to indicate understanding. Your signature at the end of this form will indicate that you understand and agree to the terms and conditions contained herein.

Supervision and Training

The PTCC has two purposes. It is responsible for providing clinical education and training for clinical and school psychology graduate students while providing the best possible assessment and treatment services to clients and families participating in its psychological services. Clinical services are provided by graduate student clinicians who are under the direct supervision of a Licensed Psychologist. The clinician and supervisor's name and contact information are listed in the PTCC Welcome Letter.

Since our graduate student clinicians are in training, they are unable to provide services under the following conditions: 1) when there is legal involvement (e.g., court ordered services), or 2) when the presenting problem involves very dangerous behavior (e.g., high suicide risk or risk of harm to another person). If your presenting concerns involve one of these situations, your student clinician will provide a referral to another mental health professional.

For supervision and educational purposes, clinical supervisors and students are required to observe assessment and treatment sessions directly or indirectly. One of the main reasons for these activities is to provide the best possible services to clients. Therefore, audio and/or video recording for assessment and treatment purposes is necessary and required. Your signature on this form grants permission to PTCC supervisors and graduate student clinicians to directly observe your sessions while in progress, to video record your sessions, and to use the recordings as described above. These recordings are not part of your medical record. You may not make your own audio or video recording of your sessions without your clinician's and supervisor's written consent.

Medical records are also reviewed for quality assurance and training purposes.

By signing below, you are granting consent to the above required clinical service conditions.

_____ _____
Signature: Client, Parent, or Guardian Date

I also consent to the use of medical record data (including treatment outcomes data, as well as audio and/or video tapes) for classroom teaching purposes (Circle One) YES NO Initials _____

I have read and understand the Supervision and Training section. Initials _____

Financial Policy

Fees charged by the PTCC are the responsibility of the client and payment is due prior to the session. The PTCC does not participate with any insurance carriers and will not bill your insurance for the services provided. Our fee for a psychological assessment is $500. Our fee for therapy is $75 per session. Clients with specific financial concerns are encouraged to discuss this with PTCC staff. A financial assistance application can be completed to determine whether you are eligible for a reduced rate for therapy sessions. If this application is not returned to the PTCC, then you are agreeing to pay the full amount for services. No fee reductions are available for psychological assessments. Payment for psychological services may be made to Central Michigan University. The Carls Center will provide you with a receipt for your payment.

Clients are financially responsible for any and all charges. No further services will be scheduled if your account becomes two or more payments behind. Clients with an unsatisfactory payment history may be referred to other providers for services. PTCC reserves the right to refer any past due accounts to a collection agency. If an account is sent to collections, the client will be responsible for all fees associated with collecting this debt, such as litigation and attorney fees. Once the account has been referred to the collection agency, it will be reported to the national credit bureaus.

I have read and understand the Financial Policy. Initials _____

Missed Appointment Policy

Missed sessions are problematic for both clients and clinicians. Therefore, we ask clients to make a commitment to attend sessions regularly. If you find it difficult to regularly attend your appointments, we ask that you reconsider whether this is the most appropriate time or type of clinic for you. At times, you may do better to terminate services and start at a later date when you are able to make a regular commitment. The PTCC policy on missed appointments is as follows: If you must cancel a session, call the clinic (989-774-3147) and leave a message for your clinician as soon as possible. If you are late for a session, clinicians are instructed to wait only 15 minutes at the clinic. If you are more than 15 minutes late, your clinician will assume that you have had to cancel the session. You may be charged for the missed session if you have not notified your therapist at least 24 hours in advance. Frequent cancellations or missed sessions may result in termination of therapy at the discretion of PTCC. After you have canceled or missed a session, it is your responsibility to contact the clinician if you want to reschedule for another time. If you wish to terminate services, we ask you to discuss this with your clinician rather than simply failing to show up. If you prefer, you may call the supervisor or clinic director if you are having difficulty with the clinician and are not able to resolve it with them directly.

I have read and understand the Missed Appointment Policy. Initials _____

Emergency and Summer Availability

The PTCC does not have 24-hour emergency coverage. We have listed some resources in case you need urgent care. There are two local 24-hour crisis lines: Community Mental Health for Central Michigan (1-800-317-0708) and Listening Ear (989-772-2918). If you are a CMU student, you can go to the Counseling Center (Foust Hall 102; 989-774-3381) or Student Health Services (Foust Hall 200; 989-774-6599) Monday through Friday between 8am-12pm and 1-5pm. If you are not a CMU student, you can go to the emergency room of the hospital nearest to you. The National Suicide Prevention Lifeline is also available 24/7 at 1-800-273-8255.

Graduate student clinicians are officially assigned to practicum at this clinic for the academic calendar. During the summer, clinician availability may change. If you wish to continue during the summer and your clinician is available, arrangements for summer sessions must be worked out, in advance, with your clinician. If you wish to

continue and your clinician is not available, we will assist you in finding alternate treatment resources in the community.

I have read and understand the information about Emergency and Summer Availability. Initials _____

Email Communication

PTCC can accommodate requests to communicate via email. Please be aware of risks associated with email communication, which include the risk of messages being intercepted in transmission or misdirected. If you would prefer to communicate via email, email communication should be limited to scheduling appointments and sending or receiving forms. Email should not be used for emergency situations, as it is not guaranteed to be responded to in a timely manner. Any clinical material should be addressed in person or via video conferencing. Depending on the content of the email message, it may be printed and filed in your medical record.

I understand the risks and consent to email communication. (Circle One) YES NO

If yes, your clinician will send you a test encrypted email prior to sending any other messages. In order to receive any follow-up emails, you must reply to the initial email.

My email address is: _____

I have read and understand the Email Communication section. Initials _____

Electronic Medical Record

All client health information, including, but not limited to, consents, psychological assessment reports, and therapy progress notes are stored in an electronical medical record system called Epic. Currently, all PTCC records are considered "sensitive" in Epic, indicating they are not readily viewable by clinicians outside of the PTCC. Outside health professionals do have the option to request authorization to your PTCC record through Care Everywhere to assist in your treatment and management of care. You do have the choice to opt out of your records being released to Care Everywhere and/or other Health Information Exchanges. If you have any questions, please contact your therapist.

One unique feature of Epic is MyChart. This is a web-based platform that provides 24-hour access to your medical records. Although there is a messaging function in MyChart, This should not be used to communicate with the PTCC.

I would like information about how to sign up for MyChart. (Circle One) YES NO

I have read and understand the Electronic Medical Record section. Initials _____

Telehealth Appointment Type

The PTCC is offering both in-person and telehealth services. The decision about whether in-person or telehealth appointments would serve you best will be made through a consultation between you, your clinician, and the supervisor. This will likely be an ongoing discussion, depending on the nature of your individual situation. All of the same PTCC policies, fees, and confidentiality laws apply to telehealth and in-person appointments.

Telehealth Appointments:

Telehealth involves the delivery of psychological care via internet technology, which can include interactive tasks using interactive audio, visual, or data communications. Telehealth appointments have the same purpose or intention as in-person appointments; however, due to the nature of the technology used, telehealth may be experienced somewhat differently than in-person sessions. There may be situations in which clinical needs may not be met through telehealth. If you would be better served by in-person services, your clinician will inform you of that.

I understand that there are risks and consequences of participating in telehealth, including but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that: 1) the transmission of information could be disrupted or distorted by technical failures; 2) the transmission of information could be interrupted by unauthorized persons; 3) the electronic storage of medical information could be accessed by unauthorized persons; 4) services could be disrupted or distorted by unforeseen technical problems; 5) telehealth services may not be as complete as in-person services. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telehealth.

To participate in telehealth, you must be present in Michigan during each appointment. You must also have access to a computer with webcam or smartphone, internet, and a private location for appointments. It is the clinician's responsibility to also have access to a computer with webcam, internet, and a private location for appointments.

I have read the above information and all of my questions have been answered. Initials _____

I want to participate in telehealth services. (Circle One) YES NO

Confidentiality and Limits to Confidentiality

Every effort will be made to keep your health information confidential. In addition to the situations outlined in the Notice of Privacy Practices, there are situations when the PTCC/your clinician may be required or permitted to disclose information without your authorization. These situations include: 1) When the clinic has knowledge, evidence, or reasonable concern regarding the abuse or neglect of a child or vulnerable adult, a report must be filed with the appropriate agency (e.g., Child Protective Services); 2) 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 (e.g., notifying the potential victim and contacting the police, and/or seeking hospitalization for the client); 3) If we believe that there is imminent or high risk that a client will physically harm themselves, we will also take protective actions; and 4) Although courts have recognized psychologist-client privilege, there may be circumstances in which a court would order the clinic or your clinician/supervisor to disclose information about your treatment. These limitations may change and, depending on the circumstance, formal legal advice may be needed.

I have read and understand the Confidentiality and Limits to Confidentiality section. Initials _____

Consent to Release Care and Treatment Information

Except as specifically authorized by me or for the purpose of continued treatment and operations as identified in the Carls Center Notice of Privacy Practices, I authorize the Carls Center for Clinical Care and Education/PTCC to discuss and release any and all information regarding my care and treatment to only those individuals listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Research Notification

In addition to providing clinical services and educating professionals, the PTCC also conducts research in an attempt to improve the quality of care and services or gather information regarding procedures, tests, and clinical equipment. The research may be done by a faculty member, a clinical supervisor, or a graduate student under the supervision of a faculty member or clinical supervisor. If you are interested in participating in a research project your consent is required so we may contact you. If contacted, you would be informed of the nature of the project and could decide about participation at that time. The quality of your clinical care will not be affected by your decision to participate and you may refuse participation at any time.

May we contact you regarding possible participation in research projects? (Circle One) YES NO

I have read and understand the Research Notification. Initials _____

CONSENT

By signing below, I consent to treatment by PTCC staff and authorize CMU to use and disclose my information as described in the Notice of Privacy Practices.

_____ Date: _____/_____/_____

Signature: Client, Parent, or Legal Guardian

_____ _____

Printed Name of Above Signature Relationship to Client