SERVICES CONSENT FORM

Client name: ___________________________ Date: ___ / ___ / _____

I hereby voluntarily consent to utilize the services provided by University of Central Oklahoma Psychology Clinic (hereafter referred to as UCO). Possible services include: individual, group, marital, or family therapy, assessment and/or consultation. As a client utilizing the services of UCO, I understand that I have a right to ask any questions I may have about the process, methods, duration, and goals of my treatment and/or assessment; the right to discuss any concerns I may have about my progress in services provided; and the right to terminate services if I feel I am not making progress.

**I have read and hereby certify that I understand the following:**

UCO operates as both an independent facility and a training and research facility for the Master’s program at UCO. This program requires supervision of all services provided by psychological associates. Supervision is provided by a licensed clinical psychology and faculty of the Psychology program.

There is a possibility that the clinician, psychological associate, and/or supervising faculty may change during the course of services.

For training or research purposes, services may be audio or video taped, and/or observed by supervisors or other psychological associates of UCO. All such individuals are bound by confidentiality.

Tapes, tests, and other information obtained during contacts with the clinic may be used for research and/or training purposes. I give consent for my individual data to be presented anonymously at professional meetings and/or published in a scientific journal.

I understand that one of my rights involves confidentiality. Within certain limits, information revealed by me will be kept strictly confidential, and will not be revealed to any other person or agency without my written permission. If I give my written permission to release information to my health insurance company, employee assistance program, or other health benefits program, I understand that clinicians or psychological associates may disclose the nature of services, the diagnosis, the dates of services, the fees charged, and other relevant information specifically requested by other mental health professionals and/or clinics.

I understand that a new federal law, HIPAA, provides new privacy protections for medical records and new patient rights with regard to the use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that the clinic provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this agreement, 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.

I understand that there are certain limits to confidentiality, in which it is required by law and/or professional ethics that a clinician or psychological associate reveal information to other persons or agencies, without my permission. These limits to confidentiality are as follows:
A. If I threaten grave bodily harm or death to a reasonably identified person, the clinician or psychological associate is required (1) to inform appropriate legal authorities and the intended victims; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

B. If I express a serious intent to grievously harm myself, it may be necessary for the clinician or psychological associate (1) to reveal information to family members and/or persons authorized to respond to such emergencies, in order to protect me from harm; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

C. If a court of law issues a legitimate court order, the clinician or psychological associate may be required to provide information that is specifically described in the court order.

D. If I am being evaluated or treated by order of a court of law, the results of the evaluation or treatment ordered may be revealed to the court.

E. If the clinician or psychological associate has good reason to suspect that a child, elderly person, or disabled person is a victim of physical abuse, sexual abuse, or neglect, he/she is required to report the abuse or neglect to the Department of Human Services and/or law enforcement authorities.

F. If I use psychological treatment and/or records on my behalf in a legal proceeding, the records must be made available to both parties by written consent.

G. UCO is required to provide information requested by a legal guardian of a minor child, including a non-custodial parent who has maintained parental status.

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

I. If I file a worker’s compensation case, UCO may be required, upon appropriate written request, to provide all clinical information relevant to or bearing upon the injury for which the claim was filed.

J. If I file a complaint or lawsuit against UCO or the professional staff, UCO may disclose relevant information regarding myself in order to defend itself.

If any of these situations were to arise, UCO would make every effort to fully discuss it with me before taking action, and would limit disclosure to what is necessary.

I understand these limitations to confidentiality as outlined above.

I also understand that the fee for psychological services is $__________________. I must give twenty-four hours notice if I wish to cancel an appointment. For therapy services, the full session fee will be charged if less than 24 hours notice is provided. Information and assistance regarding scheduling of appointments and payment for fees for psychological services are provided by the UCO Director.

I am expected to pay for services at the time they are provided, unless other arrangements have been made in advance. For assessment services, half of the fee is due at the first appointment; with the balance due before the report will be written.

I have been given a copy of this consent form for my personal records.

I understand and agree that my responsibilities as a client include the following:


2. Attempt any therapeutic assignments I have agreed to perform.
3. Disclose to my clinician or psychological associate whenever I feel in crisis and/or suicidal, to work with them to come up with a crisis plan, and to give UCO discretion regarding needed disclosures in a crisis situation both while waiting to obtain services, and while in treatment.

4. Not to come to the clinic under the influence of alcohol or other drugs. If I were to appear intoxicated, I agree to refrain from driving. Failure to do so would require UCO to make a DUI report.

5. Never bring a weapon of any sort to UCO.

6. Ask the clinician or psychological associate questions right away if I am uncertain about any aspect of my services or UCO policies.

7. Pay the agreed upon fees as scheduled.

Client or Parent/Legal Guardian (if under 18)  ________________________________


Psychological Associate:  ________________________________

or Clinician  ________________________________

Signature  Signature